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DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7341

Items 13, 14, 15, 230 6-23-58 et

07281

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb 03	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Hager Hotel		e. STREET ADDRESS Hager Hotel	
3. NAME OF DECEASED (Type or print)	First Frank	Middle Lester	Last Baker
4. DATE OF DEATH	Month June 15		Day 19
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 6, 1877
9. AGE (In years last birthday) 81	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) car repairman		11. BIRTHPLACE (State or foreign country) Leitersburg, Md.
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Unknown	14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 17. INFORMANT 717-07-9310 Mrs. Bertha Fisher, Cumberland, Md. Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		Hypertensive cardio-vascular disease Acute cerebral hemorrhage	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. None			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None			
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year None 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None
20f. (City or town) -	(County) -	(State) -	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>S. Robert Wells</i>	M.D.	CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	DATE SIGNED 6-17-58
EXAMINER'S NAME (Type) S. Robert Wells, M.D.			
22b. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 6-18-58	22c. NAME OF CEMETERY OR CREMATORIUM Rest Haven Cemetery	22d. LOCATION (City, town, or county) Hagerstown, Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md.	ADDRESS	24a. REC'D BY REGISTRAR DATE JUN 19 '58	24b. REGISTRAR'S SIGNATURE <i>Rehfeld</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7342

CERTIFICATE OF DEATH

07282

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
Washington MARYLAND		Maryland Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Claiborne		c. LENGTH OF STAY IN 1b Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Niswander Rd. Claiborne		e. STREET ADDRESS Niswander Rd. Claiborne	
3. NAME OF DECEASED (Type or print) Charles William Barnhart		4. DATE OF DEATH June 2, 1958	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 15, 1867	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Franklin Pa Roma		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Barnhart		14. MOTHER'S MAIDEN NAME Margaret Russell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) Generalized arteriosclerosis		18. INFERVAL BETWEEN ONSET AND DEATH 8 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/1/1957, to 6/2/1958, that I last saw the deceased alive on 5/29/1958, and that death occurred at 5:00 PM, from the causes and on the date stated above. ACTUAL SIGNATURE George Jennings PHYSICIAN'S NAME (Type) George Jennings		ADDRESS (Street, city or town, state) M.D. 136 W. Washington St. 6/3/58 Hagerstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/4/1958	
22c. NAME OF CEMETERY OR CREMATORIUM Zion Cemetery		22d. LOCATION (City, town, or county) Claiborne Wash. Co Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Harold W. Zimmerman, Greenfield Pa		24a. REC'D BY REGISTRAR DATE 6/5 '58	
		24b. REGISTRAR'S SIGNATURE Albert	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7284

CERTIFICATE OF DEATH

Reg. Dist. No.

07283

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Washington MARYLAND		a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY Washington	
Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
c. LENGTH OF STAY IN lb 2 Days		d. STREET ADDRESS X Hancock Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Richard	Middle Coe
4. DATE OF DEATH		Month 6	Day 30
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
M W		8. DATE OF BIRTH 6.28.58	
9. AGE (in years lost birthday) yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 2 Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY Infant	
11. BIRTHPLACE (State or foreign country) Washington County Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard L Bartles		14. MOTHER'S MAIDEN NAME Charlotte L Brannon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT		Address Richard L Bartles Hancock Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 2 days	
776X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		Prematurity	
DUE TO (b)		Premature labor	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
none			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 28, 1958, to June 30, 1958, that I last saw the deceased alive on June 30, 1958, and that death occurred at 10:30 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Clear Spring, Maryland DATE SIGNED 7/2/58	
ACTUAL SIGNATURE Archie Robert Cohen M.D.			
PHYSICIAN'S NAME (Type) Archie Robert Cohen, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7.2.58	
22c. NAME OF CEMETERY OR CREMATORIUM Riverview Cemetery		22d. LOCATION (City, town, or county) Hancock Washington Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Howard J. Glavin Hancock Md.		ADDRESS DATE JUL 8 '58	
		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE Archie	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07284

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)		
Washington MARYLAND		Sharpsburg Pot. River Bridge				Md. Wash.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
				Hagerstown				
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
Leroy		W	Beard		6	22	1958	
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
male	white	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Feb. 11, 1940	18 yrs.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
laborer		Michael Ice Co.		Hagerstown, Md.		U.S.A.		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME						
Joseph L. Beard		Helen Wolfensberger						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		
		219-36-4323		Joseph L. Beard		Hagerstown, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Open fracture skull DUE TO 202X								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)								
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Cause of death. Hit by train on Railroad Bridge								
20c. TIME OF INJURY Hour 12:27 p.m.		Month, Day, Year June 22 1958	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Railroad Bridge		20f. (City or town) Rural Sharpsburg	(County) Wash (State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>								
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		S. Robert Wells		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 6-23-58		
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 6-24-58		22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill		22d. LOCATION (City, town, or county) Hagerstown (State) Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss		ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR JUN 24 1958		24b. REGISTRAR'S SIGNATURE John E. Smith		

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07285

7344

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Washington MARYLAND		a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Williamsport Sanitarium		d. STREET ADDRESS 1 67 East Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Thomas		First Fountain	Middle Biershing
4. DATE OF DEATH		Month June	Day 21
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
Male		White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH		9. AGE (In years last birthday) 83 yrs.	
May 29, 1875		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Retail	
11. BIRTHPLACE (State or foreign country) Rohersville Md.		12. CITIZEN OF WHAT COUNTRY? Hagerstown Md.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
George Biershing		Amanada Gelthmacher	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
214-09-1941 Miss Elizabeth Artz		Hagerstown Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 B. Broncho Pneumonia		1 wk	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		4 yrs.	
(b) Arterio-sclerotic Heart Disease		4 yrs.	
DUE TO Arteriosclerosis - generalized		4 yrs. +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
491X			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Mar 28</u> , 1951 to <u>June 21</u> , 1955 that I last saw the deceased alive on <u>July 22</u> , 1955, and that death occurred at <u>4:29 P.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>6/21/55</u> DATE SIGNED <u>6/23/55</u>	
ACTUAL SIGNATURE <u>Lloyd A. Hoffman</u>		M.D. <u>214 N. Potomac St.</u>	
PHYSICIAN'S NAME (Type) <u>Lloyd A. Hoffman</u>		Hagerstown Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-24-58	
22c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery		22d. LOCATION (City, town, or county) Hagerstown Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son		ADDRESS <u>Hagerstown Md.</u>	
VS A15 (4) 15M 9/55		24a. REC'D BY REGISTRAR DATE <u>June 25 58</u>	
		24b. REGISTRAR'S SIGNATURE <u>D. L. Smith</u>	

野火燎原——中国革命的火种与燎原——37A7 09437801

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7285

CERTIFICATE OF DEATH

07286

Reg. Dist. No.

1. PLACE OF DEATH
o COUNTY

Washington

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Hagerstown

c. LENGTH OF STAY IN lb

2 yrs.

d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

116 Fairground Ave.

2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission)

a. STATE

Maryland

b. COUNTY

Washington

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

03 Hagerstown

d. STREET ADDRESS

116 Fairground Ave.

e. IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or print)First
MAEMiddle
ROSA

BITNER

4. DATE
OF
DEATHMonth
June
Day
20, 1958

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

Feb. 19, 1897

9. AGE (In years
at death, birthday)61
yrs

10. IF UNDER 1 YEAR

Months
0
Days
0

11. IF UNDER 24 HRS

Hours
0
Min
0

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

Md.
Wolftesville-Fred. Co.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

William Bitner

14. MOTHER'S MAIDEN NAME

Lollie Kendall

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or date of service)

10

16. SOCIAL SECURITY NO.

219-05-3925

17. INFORMANT

Roy J. Bitner-116 Fairground Ave.-Hag.

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a)

CORONARY Occlusion

INTERVAL BETWEEN
ONSET AND DEATH
10 min.

420.1

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b)

DUE TO

(c)

CORONARY ArTERIOSCLEROSIS

2415

MEDICAL CERTIFICATION

19. WAS AUTOPSY PERFORMED? YES NO

Hypertension; Obesity

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, notify medical examiner)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour o. m. 19
p. m.20d. INJURY OCCURRED
While
at work Not while
at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from July 1, 1957 to June 26, 1958 that I last saw the deceased
alive on July 10, 1958, and that death occurred at 4:30 M, from the causes and on the date stated above

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE

Paul Harrison

M.D. 318 N. Potomac St.

6-21-58

PHYSICIAN'S
NAME (Type) Paul Harrison, M. D.

Hagerstown, Md.

22a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial

22b. DATE THEREOF

6-23-58

22c. NAME OF CEMETERY OR CREMATORIUM

Cedar Hill Cemetery

22d. LOCATION (City, town, or county)

Greencastle, Penn.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

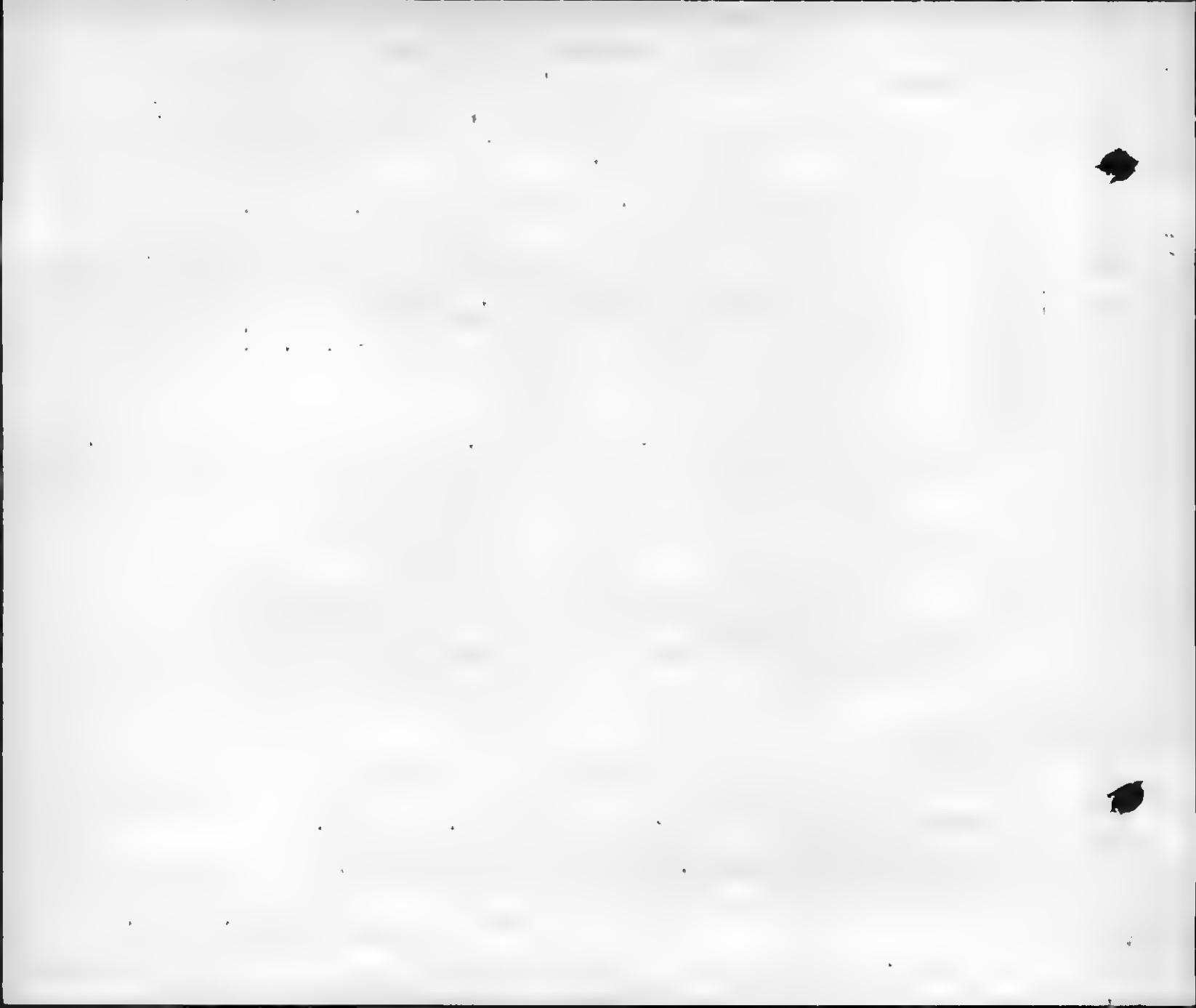
Andrew K. Coffman-Hagerstown, Maryland

24a. REG'D BY REG'ISTRAR

JUN 26 1958
DATE

24b. REG'ISTRAR'S SIGNATURE

Coffman



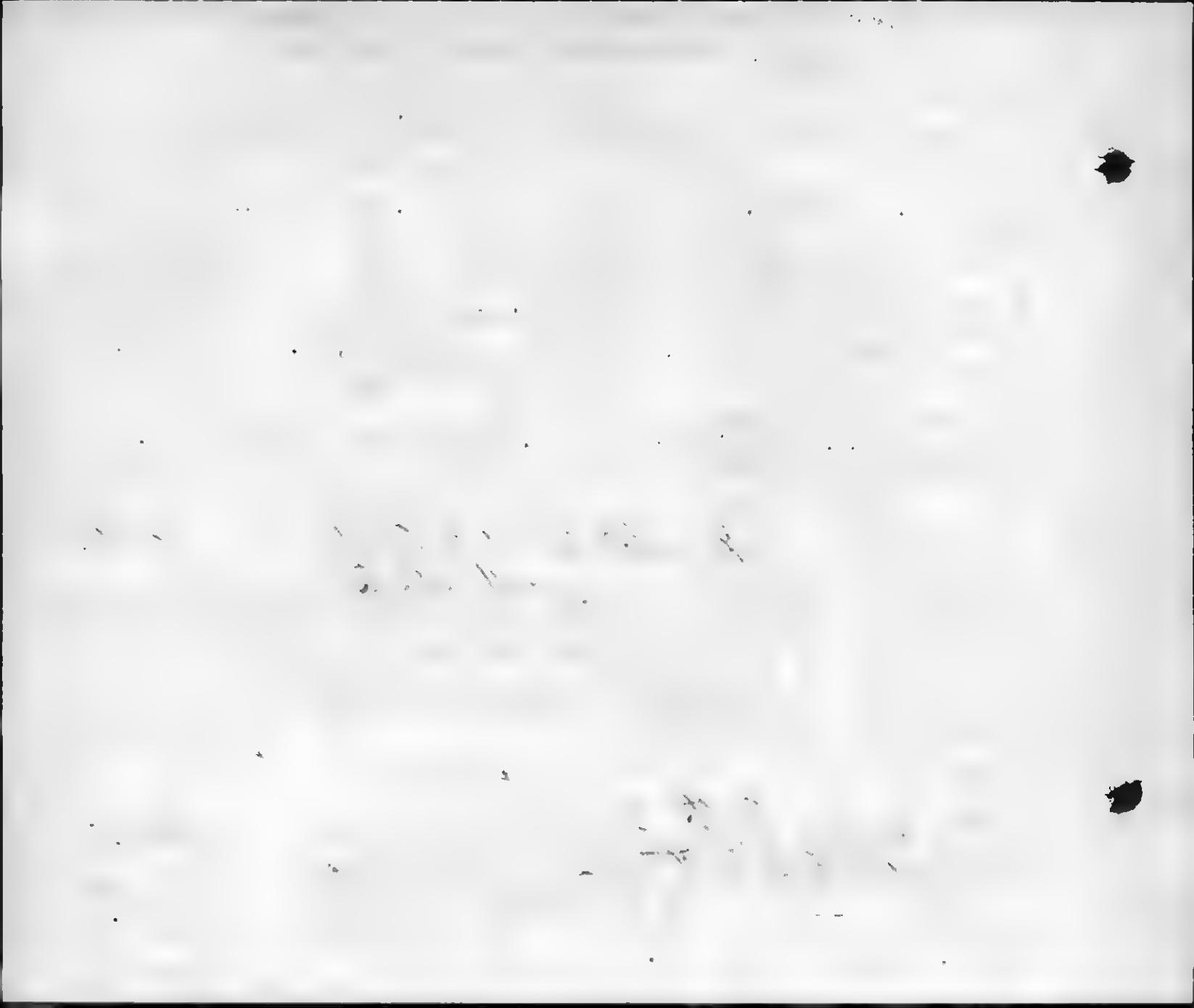
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07287

Reg. Dist. No.

7286

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE					
Washington MARYLAND		Md. Washington					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b life					
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		d. STREET ADDRESS 207 N. Mulberry St.,					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 207 N. Mulberry St.		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First Charles	Middle M				
Last Bond		4. DATE OF DEATH 6	Month 4				
5. SEX male		6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				
8. DATE OF BIRTH Aug. 7, 1917		9. AGE (In years last birthday) 40 yrs.	10. IF UNDER 1 YEAR Months Days				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bar Tneder		10b. KIND OF BUSINESS OR INDUSTRY Jimmie Rays Tavern	11. BIRTHPLACE (State or foreign country) Hagerstown, Md.				
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Benjamin Bend		14. MOTHER'S MAIDEN NAME Daisy Johnson					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. W.W. II	17. INFORMANT Mrs. Jeanette Bond				
		Address Hagerstown, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)							
116X Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <i>Gun shot Wound of head</i> DUE TO (c) <i>self inflicted</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>John W. Ditta</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <i>6/4/58</i>			
EXAMINER'S NAME (Type) <i>John W. Ditta</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 6-6-58		22c. NAME OF CEMETERY OR CREMATORIAL Arlington National		22d. LOCATION (City, town, or county) Arlington	
(State)						(State) Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss		ADDRESS Hagerstown, Md.		24a. RECD BY REGISTRAR JUN 9 '58		24b. REGISTRAR'S SIGNATURE <i>John W. Ditta</i>	
VS. A15ME(S) 5M 9/55				DATE			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07288

7287

CERTIFICATE OF DEATH

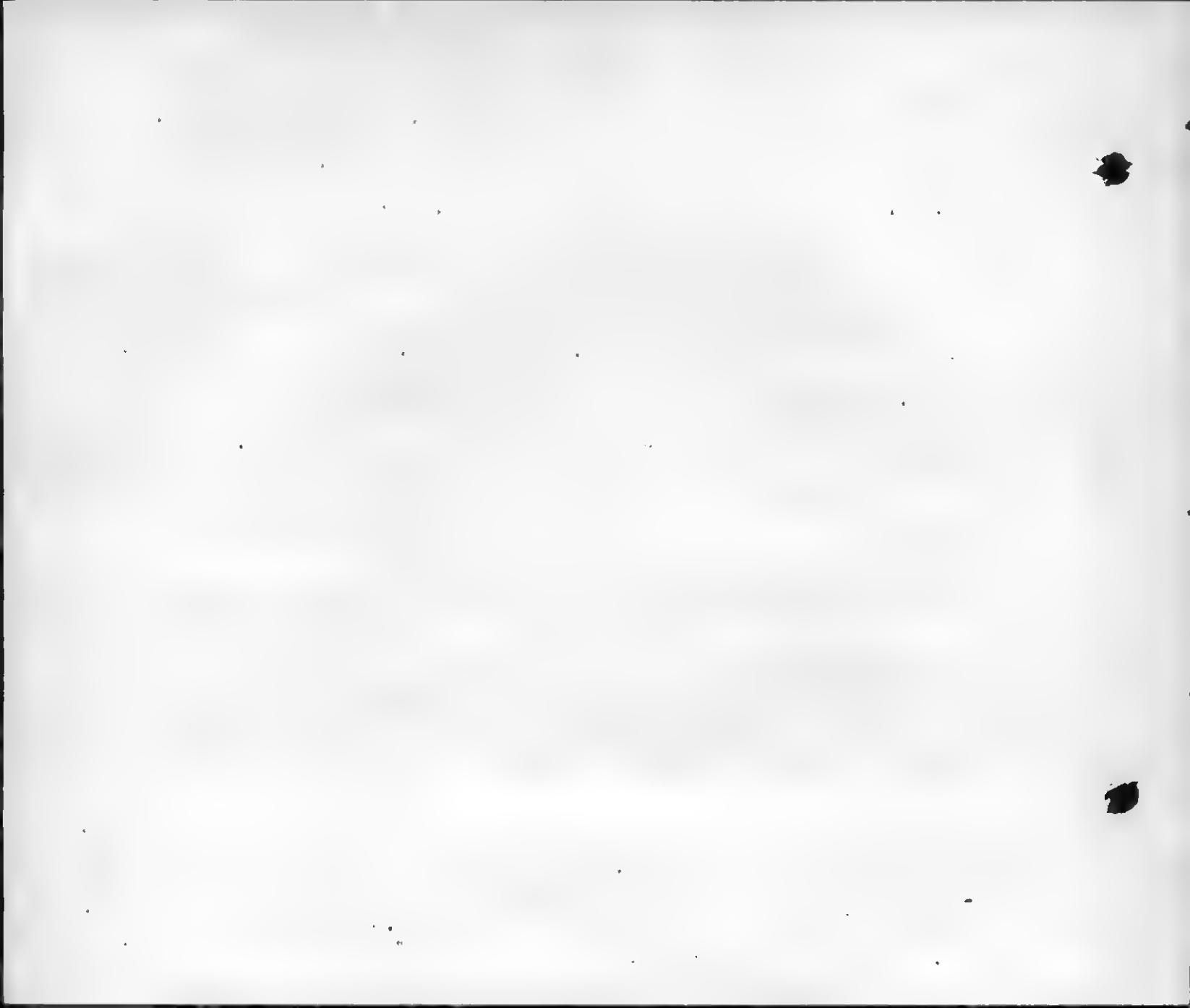
Reg. Dist. No.

1

HOSPITAL OR ATTENDING PHYSICIAN—The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR—After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be retained for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to a burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Md. b. COUNTY Balto.							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb 2 days							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. Co. Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 25, Md. ✓ 3 VOL. 4							
3. NAME OF DECEASED (Type or print) Viola (Limburg)		d. STREET ADDRESS 3902 S. Hanover St., e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
4. DATE OF DEATH Month 6 Day 10 Year 58 19									
5. SEX female white		6. COLOR OR RACE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 9, 1922		9. AGE (In years last birthday) 36 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laundrette		10b. KIND OF BUSINESS OR INDUSTRY Brooklyn Appl. Store		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY U.S.A.			
13. FATHER'S NAME P.A. Limburg		14. MOTHER'S MAIDEN NAME Minnie Belle Schlier							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no or unknown) no		16. SOCIAL SECURITY NO 220-10-3198		17. INFORMANT George Borne		Address Baltimore, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause, if any. (b) DUE TO (c)				Mild Lymphatic Leukemia		INTERVAL BETWEEN ONSET AND DEATH 4 wks.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>June 8, 1958</u> to <u>June 10, 1958</u> that I last saw the deceased alive on <u>June 8, 1958</u> and that death occurred at <u>152 W. Washington St., Hagerstown, Md.</u> from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED 6/11/58			
ACTUAL SIGNATURE <u>Philip J. Hirshman</u>									
PHYSICIAN'S NAME (Type) Philip J. Hirshman, M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 6-13-58		22c. NAME OF CEMETERY OR CREMATORIAL Rose Hill		22d. LOCATION (City, town, or county) Hagerstown (State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss		ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE 6/16/58		24b. REGISTRAR'S SIGNATURE <u>Philip J. Hirshman</u>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7288

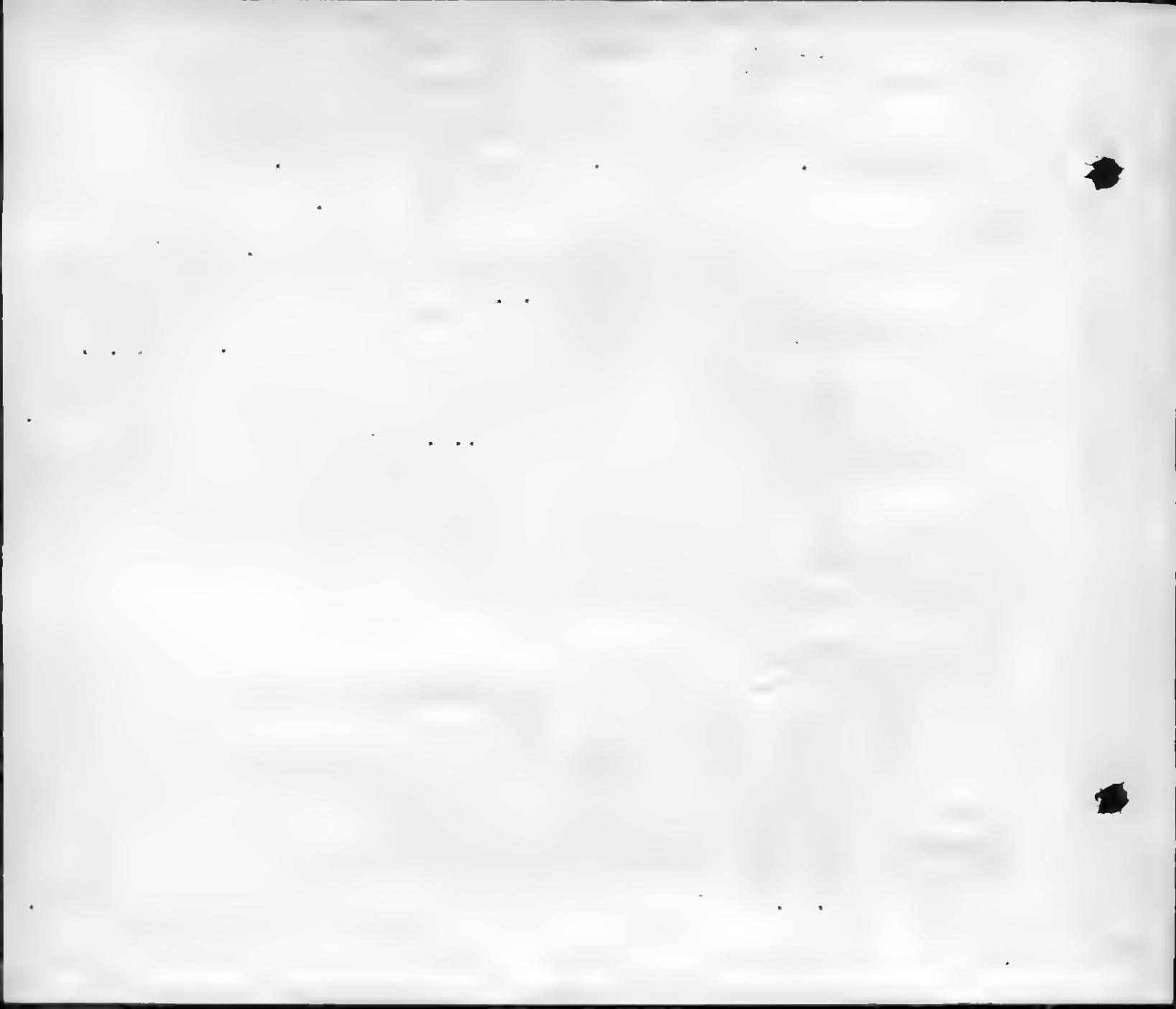
CERTIFICATE OF DEATH

Reg. Dist. No.

07289

1. PLACE OF DEATH o COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Md.		c. LENGTH OF STAY IN 1b 40 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Ella	Middle Katherine	4. DATE OF DEATH Bostetter 6. 27 1958
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 9.7.1875
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Keeper		10b. KIND OF BUSINESS OR INDUSTRY House Keeper	
11. BIRTHPLACE (State or foreign country) Washington County Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Martin V Bostetter		14. MOTHER'S MAIDEN NAME Barbara A Sprecher	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Martin V. B. Bostetter		Address Hagerstown Md. 520 Salem Ave	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 2 days	
DUE TO Arterio Sclerosis			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause (b) None			
DUE TO None			
DUE TO None			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D.		20f. (City or town) Hagerstown (County) Md. (State) Md.	
21. I certify that I attended the deceased from June 26, 1958 to June 27, 1958 , that I last saw the deceased alive on June 26, 1958 and that death occurred at Hagerstown , M.D., from the causes and on the date stated above. ACTUAL SIGNATURE W. Beachley ADDRESS (Street, city or town, state) Hagerstown, Md. DATE SIGNED July 3, 1958			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6.30.58	
22c. NAME OF CEMETERY OR CREMATORY Broadfording Cemetery		22d. LOCATION (City, town, or county) Broadfording Washington Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Howard & Son Funeral Home		ADDRESS	
		24a. REC'D. BY REGISTRAR DATE JUL 3 1958	
		24b. REGISTRAR'S SIGNATURE W. Beachley	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial/transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be filed for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7289

CERTIFICATE OF DEATH

 Reg. Dist. No. 07290

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Md. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 28 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. Co. Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
3. NAME OF DECEASED (Type or print) Elise		d. STREET ADDRESS 29 Glenside Ave.,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX female white		6. COLOR OR RACE WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
8. DATE OF BIRTH June 27, 1899		9. AGE (In years last birthday) 58 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher		10b. KIND OF BUSINESS OR INDUSTRY Public Schools	
11. BIRTHPLACE (State or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Ordway E. Garmong		14. MOTHER'S MAIDEN NAME Emeline Strite	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 17. INFORMANT 220-18-2276 Scott R. Bounds Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 12 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/11/30, 19, to 6/17/30, 19, that I last saw the deceased alive on 6/15/30, 19, and that death occurred at Hagerstown, Md., from the causes and on the date stated above. ACTUAL SIGNATURE <i>Dr. E. D. Ordway</i> ADDRESS (Street, city or town, state) <i>Hagerstown, Md.</i> DATE SIGNED <i>6/17/30</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 6-10-58	
22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill		22d. LOCATION (City, town, or county) Hagerstown (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss		ADDRESS Hagerstown, Md.	
24a. REC'D BY REGISTRAR DATE JUN 11 1958		24b. REGISTRAR'S SIGNATURE <i>John Kraiss</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7290

CERTIFICATE OF DEATH

Dr. Lusby

07291

Reg. Dist. No.

302

PLACE OF DEATH
a. COUNTY

Washington

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Hagerstown

c. LENGTH OF STAY IN 1b

2 weeks

d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

Washington City. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE

Maryland

b. COUNTY

Washington

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Hagerstown

d. STREET ADDRESS

1083 Marshall St.

e. IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or print)First
CarrieMiddle
MayLast
Bowers4. DATE
OF
DEATHMonth
JuneDay
26Year
1958

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

9. AGE (In years
lost birthday)

10. IF UNDER 1 YEAR

11. IF UNDER 24 HRS

Months

Days

Hours

Min

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Housewife

Own Home

Funkstown, Md.

12. CITIZEN OF WHAT COUNTRY

U.S.A.

13. FATHER'S NAME

Charles A. Zeigler

14. MOTHER'S MAIDEN NAME

Virginia Lee Williams

Address

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)
(If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

17. INFORMANT

None

Mrs. Virginia Duttinger, Hagerstown, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Hypertension-ArterioSclerotic Heart Disease

INTERVAL BETWEEN
ONSET AND DEATH

5 yrs. +

21- ✓

DUE TO

Diabetes Mellitus

5 yrs. +

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause lost.

DUE TO

Incarcerated Umbilical Hernia - Apertitus

1 week

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

Primary Cardiac Disease

19. WAS AUTOPSY
PERFORMED?
YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, notify medical examiner)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour o. m. 19
p. m.20d. INJURY OCCURRED
While at work Not while at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from 1953 to 26 June 1958, that I last saw the deceased alive on 26 June 1958, and that death occurred at 12:30 P.M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

ACTUAL
SIGNATURE

J. F. Lusby

DATE SIGNED
27 JUN 58PHYSICIAN'S
NAME (Type)

F. F. Lusby

22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial 6/29/1958 Lutheran Cemetery

22d. LOCATION (City, town, or county)

(State)

Bakersville Wash. Cty., Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS

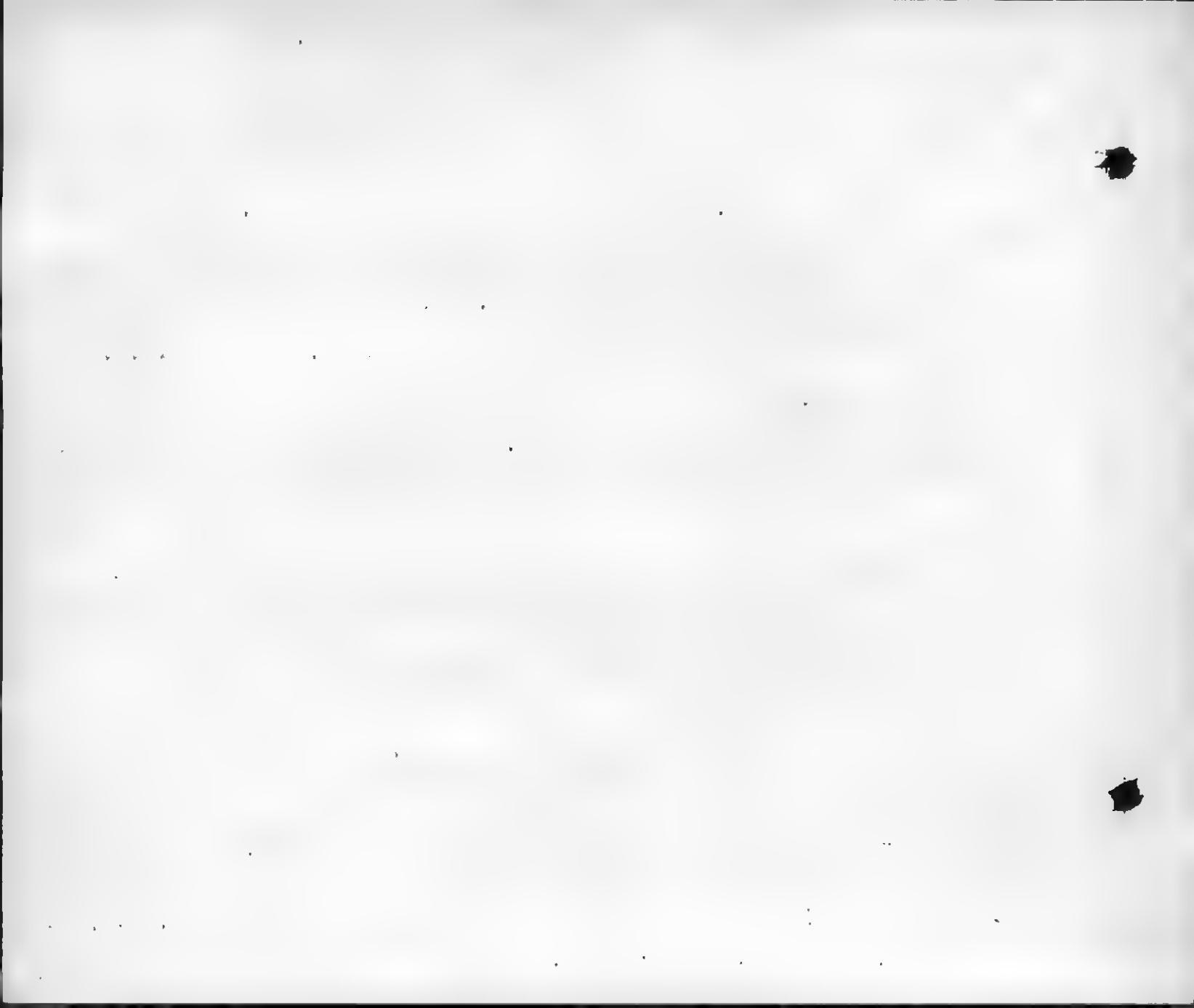
Andrew K. Cofman Hagerstown Md.

24a. REC'D BY REGISTRAR

DATE JUN 30 '58

24b. REGISTRAR'S SIGNATURE

C. L. Lusby



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be checked for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 7291 CERTIFICATE OF DEATH

07292

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE [Where deceased lived if institution Residence before admission] a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Md.		b. COUNTY Washington	
c. LENGTH OF STAY IN 1b 4 years.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Co., Hospital		d. STREET ADDRESS North Colonial Park	
3. NAME OF DECEASED (Type or print) WILLIAM D. BOWERS		First	Middle
4. DATE OF DEATH JUNE 22 1958		Last	Month
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 11, 1872
9. AGE (In years from birthday) 86 yrs.		10. IF UNDER 1 YEAR; IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) employee		10b. KIND OF BUSINESS OR INDUSTRY Woolen Mill	
10c. BIRTHPLACE (State or foreign country) Washington Co., Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME John Bowers		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Mrs. Carrie Hite	
17. INFORMANT North Colonial Park, Hagerstown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b). DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the under- lying cause last (c). DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the under- lying cause last		INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18] Death due to heart disease	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 3:35 P.M.	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D. 159 W. Washington St., Hagerstown, Md.		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from alive on June 23, 1958 , and that death occurred at 3:35 P.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) Philip J. Hirshman, M.D.		DATE SIGNED 6/23/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-25-1958	
22c. NAME OF CEMETERY OR CREMATORIAL Smoketown		22d. LOCATION (City, town, or county) Martinsburg, Berkeley Co., W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard K. Brown		24a. ADDRESS Martinsburg, W. Va.	
24b. REC'D. BY REGISTRAR JUN 25 '58		24c. REGISTRAR'S SIGNATURE Ch.	
VS A15 (4) 15M 10/57			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7292 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07293

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 2 weeks	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		e. STREET ADDRESS 1935 W. Washington Street	
f. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		g. DATE OF DEATH June 9 1958	
3. NAME OF DECEASED (Type or print) URIAH	First GRANT	Middle BOWSER	Month Year 54 yrs 3 29 months 29 days Hours 15 min.
4. SEX Male	5. COLOR OR RACE White	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> February 10, 1904	7. KIND OF BUSINESS OR INDUSTRY Grocery Business
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		11. BIRTHPLACE (State or foreign country) Adrian, Pennsylvania	
13. FATHER'S NAME Uriah F. Bowser		14. MOTHER'S MAIDEN NAME Bertha Z. Mc Millen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Vol. no. or unknown) no		16. SOCIAL SECURITY NO 215-18-1313	
17. INFORMANT Mr. Uriah F. Bowser Hagerstown, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (b) DUE TO (c) <i>Arterial embolism + multiple pulmonary emboli secondary to septic thrombosis of liver Extent</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) <i>Fallen from into park car on W. Washington St (11th block)</i>	
20c. TIME OF INJURY Month Day, Year 5-27 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) at Washington	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		21. ACTUAL SIGNATURE Dr. D. W. Dillinger DATE SIGNED 6/11/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/13/1958	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Montgomeryville Baptist Cem. Hagerstown, Md.		22d. LOCATION (City, town, or county) Montgomeryville, Penn.	
23. FUNERAL DIRECTOR'S SIGNATURE Suter-Rouzer Funeral Home		24a. REC'D BY REGISTRAR REG STAR'S SIGNATURE	
24b. DATE June 12 '58		24c. DATE June 12 '58	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7293 CERTIFICATE OF DEATH

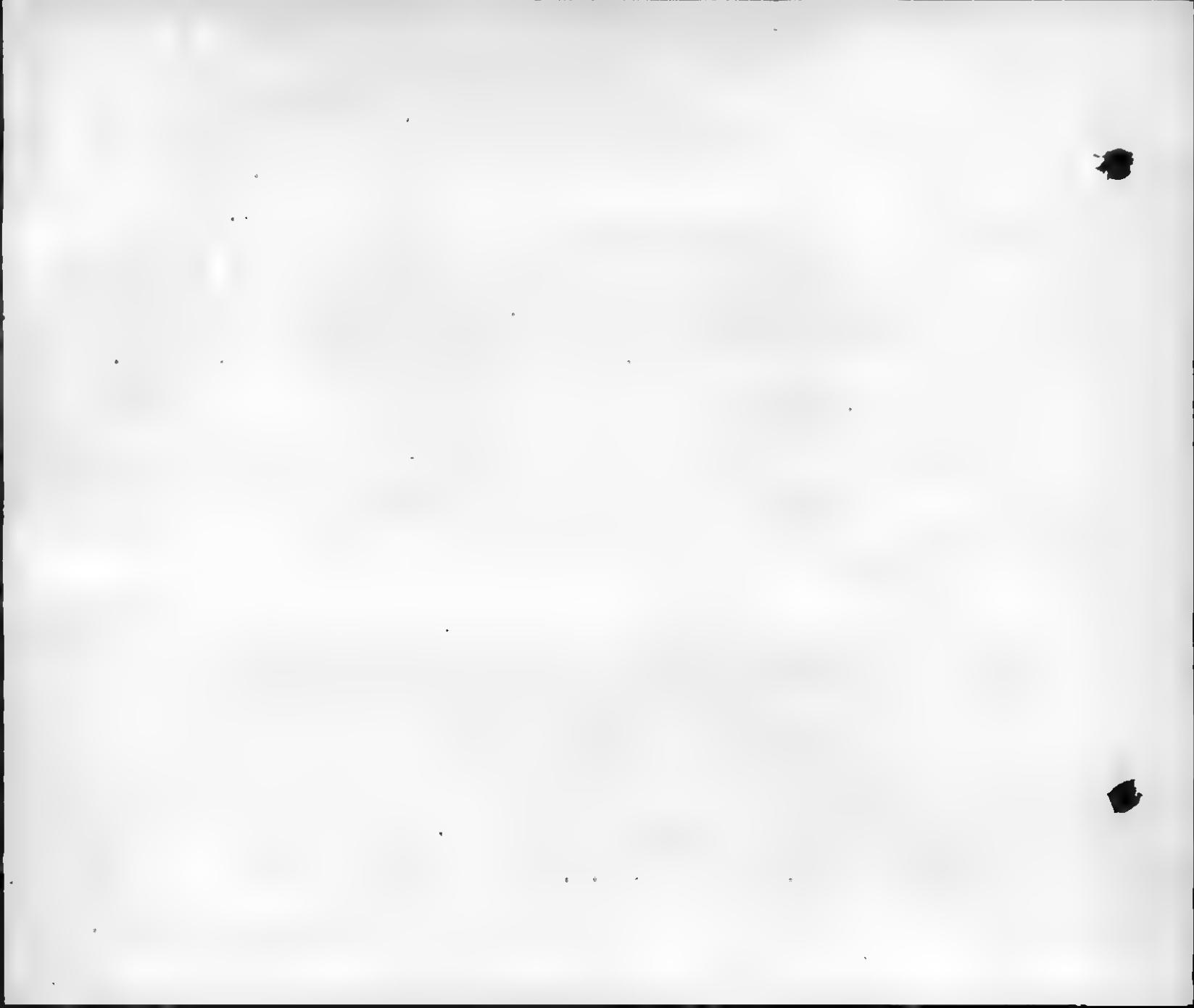
07294

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived) <input type="checkbox"/> b. institution: Residence before admission		a. STATE Pa.		b. COUNTY Franklin		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b Hagerstown 2 Weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Waynesboro Pa. 10A				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Ave. Martin Manor Rest Home, 1223 Virginia		d. STREET ADDRESS		106 Garfield St.		e. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First IRVIN	Middle G.	Last BREIDENTHAL	4. DATE OF DEATH	JUNE	Month	Day	Year	
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday) 89 yrs.	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS	12. IF UNDER 24 HRS		
Male		White	WIDOWED <input checked="" type="checkbox"/>	Divorced <input type="checkbox"/>	Oct. 27, 1868	Months	Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?				
Retired Foreman		Frick Co.		Morrison Cove, Bedford Co.		U.S.A.				
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME								
David S. Breidenthal		Esther Rhodes								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> No		16. SOCIAL SECURITY NO. 204-01-4035		17. INFORMANT		Address				
				John E. Breidenthal, Waynesboro Pa.						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Arteriosclerotic heart disease -							5 yrs.	
DUE TO										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Generalized arteriosclerosis							10 yrs	
(b)										
DUE TO										
(c)		+ cerebral thrombosis								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		Right inguinal hernia - Benign prostatic hypertrophy							19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)	
19										
21. I certify that I attended the deceased from <u>May 25, 1958</u> to <u>June 6, 1958</u> , that I last saw the deceased alive on <u>June 4, 1958</u> , and that death occurred at <u>10:20 A.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state)							DATE SIGNED	
ACTUAL SIGNATURE <u>Edward W. Dittto</u>		M.D. 217 W. Washington Street							6/6/58	
PHYSICIAN'S NAME (Type) <u>Edward W. Dittto, M.D.</u>		Hagerstown, Maryland								
22a. BURIAL, CREMATION, REMOVAL (Specify) <input type="checkbox"/> Burial		22b. DATE THEREOF <u>6/9/58</u>		22c. NAME OF CEMETERY OR CREMATORIAL <u>Green Hill</u>		22d. LOCATION (City, town, or county) <u>Waynesboro, Franklin, Pa.</u>		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Y. Glavin</u>		ADDRESS <u>Waynesboro, Pa.</u>		24a. REC'D BY REGISTRAR <u>W. Glavin</u>		24b. REGISTRAR'S SIGNATURE <u>W. Glavin</u>		DATE <u>JUN 10 '58</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the registrar.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7295 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07295

1. PLACE OF DEATH a. COUNTY Washington MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Howard		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb 29 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital			d. STREET ADDRESS 423 S. Ann Street		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First William	Middle Gordon	Last Clark	4. DATE OF DEATH June 20	Month Day Year 19 58
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH April 27, 1940	9. AGE (In years last birthday) 18 yrs.	10. IF UNDER 14 YEARS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laboring		10b. KIND OF BUSINESS OR INDUSTRY Various jobs		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME John W. Clark			14. MOTHER'S MAIDEN NAME Anna Marie Ganzermiller		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-36-3859		17. INFORMANT Mr. John W. Clark- Father- Baltimore, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intra cerebral hemorrhage</u> INTERVAL BETWEEN ONSET AND DEATH <u>29 days</u> DUE TO <u>Cerebral Contusions</u> <u>29 days</u> Conditions, if any, which gave rise to immediate cause (b) <u>Cerebral Congestion and edema</u> <u>29 days</u> (c) <u>Pulmonary infarct and embolies - small</u> <u>48 hrs</u> DUE TO <u>183X</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Beaten and kicked by inmates at reformatory			
20c. TIME OF INJURY Hour <u>11:15</u> p.m. Month, Day, Year <u>May 23 1958</u>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Reformatory 20f. (City or town) (County) (State) Rural Hagerstown Wash Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/>					
ACTUAL SIGNATURE <i>S. Robert Wells</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 6-20-58
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JUNE 24-58		22c. NAME OF CEMETERY OR CREMATORIAL MT CARMEL CEM	
22d. LOCATION (City, town, or county) ODONNELL ST MD				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE WENDELL J DIPPEL 3125 HIGHLAND AVE		ADDRESS		24a. REC'D. BY REGISTRAR JUN 24 58	24b. REGISTRAR'S SIGNATURE <i>Wendell J Dippel</i>



HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7295 CERTIFICATE OF DEATH

Reg. Dist. No. 07296

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland		b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 3 Hrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Boonsboro R # 2		d. STREET ADDRESS Rohrersville Road		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. County Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First JOHN	Middle DANIEL	Last CLAY	4. DATE OF DEATH	Month June	Day 24	Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH May 20 1878	9. AGE (In years last birthday) 80 yrs	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0	Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Ky Louisville Jefferson Co		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME John Clay				14. MOTHER'S MAIDEN NAME Elizabeth James				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or No or Unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Margie Clay Boonsboro Md. R # 2		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] Part I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4/20/1 <i>Deceased by throat disease</i> Day Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO Part II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.	Month 6/23/58	Day 19	Year 1958	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Boonsboro	(County) Jefferson Co	(State) Md.
21. I certify that I attended the deceased from 6/23/58 to 6/24/58 , that I last saw the deceased alive on 6/24/58 , and that death occurred at 2:30 PM , from the causes and on the date stated above ACTUAL SIGNATURE <i>Leigh T. Young M.D.</i> ADDRESS (Street, city or town, state) <i>William Street, Hagerstown, Md.</i> DATE SIGNED <i>6/25/58</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/26/58	22c. NAME OF CEMETERY OR CREMATORIAL Lennonite Cemetery	22d. LOCATION (City, town or county) Pinesburg Wash. Co Md.	(State)				
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.	ADDRESS	24a. REC'D BY REGISTRAR DATE JUN 26 '58	24b. REGISTRAR'S SIGNATURE <i>Asst. Sec. 1</i>					



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07297

7345

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland		b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown R # 4		c. LENGTH OF STAY IN lb 2½ yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown R # 4				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Broadfording Church Road				d. STREET ADDRESS Broadfording Church Road		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) DIANNA LYNN CUNNINGHAM		First	Middle	Last	4. DATE OF DEATH June 28 1958	Month	Day	Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 10 1955	9. AGE (In years last birthday) 2 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	Hours
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Hagerstown Wash. Co Md.		12. CITIZEN OF WHAT COUNTRY USA		
13. FATHER'S NAME Harry F. Cunningham				14. MOTHER'S MAIDEN NAME Esther Lowen				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT Harry F. Cunningham		Address Hagerstown R # 4		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4 DUE TO hurso B lastom as Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)				near Cearfoss		INTERVAL BETWEEN ONSET AND DEATH 6 hrs		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, hotel, office bldg., etc.)		20f. (City or town) Hagerstown		(County) (State) Wash. Co Md.
21. I certify that I attended the deceased from 12/28/58 to 6/28/58, that I last saw the deceased alive on 6/27/58, and that death occurred at 1:30 P.M. from the causes and on the date stated above.						ADDRESS (Street, city or town, state) Wash. Co Md.		DATE SIGNED 6/28/58
ACTUAL SIGNATURE Daphne Cunningham								
PHYSICIAN'S NAME (Type) Andrew K. Coffman								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/30/58		22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery		22d. LOCATION (City, town or county) Hagerstown Wash. Co Md.		(State)
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE JUN 2 '58		24b. REGISTRAR'S SIGNATURE Coffman		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



07298

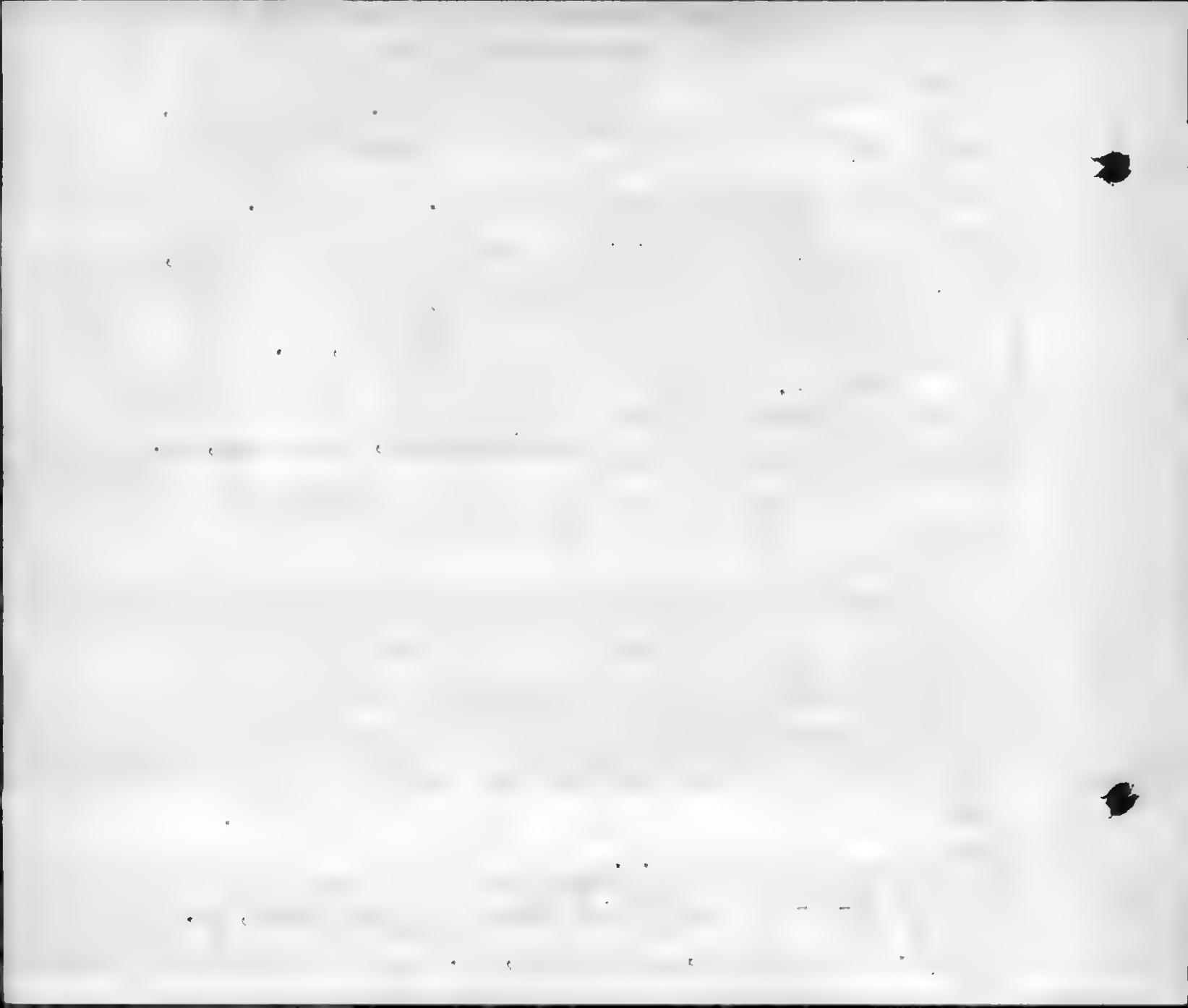
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7296 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Md. b. COUNTY Wash.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 16		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		d. STREET ADDRESS 310 E. Franklin St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Mary	Middle Virginia	Last Cushwa	4. DATE OF DEATH June 9,	Month 1958	Day Year
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 11, 1924	
9. AGE (In years last birthday) 33 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? James City, Pa.	
13. FATHER'S NAME George J. Brothers				14. MOTHER'S MAIDEN NAME Florence Witherup			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.		17. INFORMANT William Cushwa, Hagerstown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)				cirrhosis liver, hepatic coma		INTERVAL BETWEEN ONSET AND DEATH sev. weeks years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) pneumonia							
20c. TIME OF INJURY Month, Day, Year Hour o. r. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/29/58, 19, to 6/9/58, 19, that I last saw the deceased alive on 6/8/58, 19, and that death occurred at AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 136 North Potomac St. DATE SIGNED 6/10/58							
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Howard N. Weeks, M.D.		Hagerstown, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 6-11-58		22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md.				ADDRESS		24a. REC'D BY REGISTRAR DATE Jun 12 '58	
						24b. REGISTRAR'S SIGNATURE J. L. Green	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
Page 3 should be attached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07299

7297

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Maryland		c. LENGTH OF STAY IN 1b 6 years.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Maryland		d. STREET ADDRESS 44 W. Bethel Street		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 44 W. Bethel Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Ara		First	Middle Bell	Lost	4. DATE OF DEATH Dersey	Month June	Day 5	Year 1958
5. SEX Female		6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 18 1881		9. AGE (In years lost birthday) 77 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Greencastle Pa.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Massey Dersey		14. MOTHER'S MAIDEN NAME Sara Smith						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT Miss Fannie Smith		Address Greencastle Pa.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		DUE TO <i>Arthritis of the knee & hand</i>		INTERVAL BETWEEN ONSET AND DEATH 2 yrs.				
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last		(b)	<i>Arthritis of the knee & hand</i>		Year 2 yrs.			
		(c)	<i>Senility</i>		Years 40 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>At home</i>		20f. (City or town) Hagerstown	(County) Hagerstown	(State) Md
21. I certify that I attended the deceased from <i>28 May 1958</i> to <i>12 June 1958</i> , that I last saw the deceased alive on <i>28 May 1958</i> , and that death occurred at <i>Hagerstown</i> M, from the causes and on the date stated above.				ADDRESS (Street, city or town, state) 159 W. Washington St., Hagerstown, Md.		DATE SIGNED 6/9/58		
ACTUAL SIGNATURE <i>Philip J. Hirshman</i>		PHYSICIAN'S NAME (Type) Philip J. Hirshman, M.D.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-9-1958		22c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery		22d. LOCATION (City, town, or county) Hagerstown Md.		
23. FUNERAL DIRECTOR'S SIGNATURE <i>John R. Watson</i>		ADDRESS <i>Hagerstown Md.</i>		24a. REC'D. BY REGISTRAR DATE JUN 12 1958		24b. REGISTRAR'S SIGNATURE <i>John R. Watson</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

left uninterrupted by water

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Dr Packer

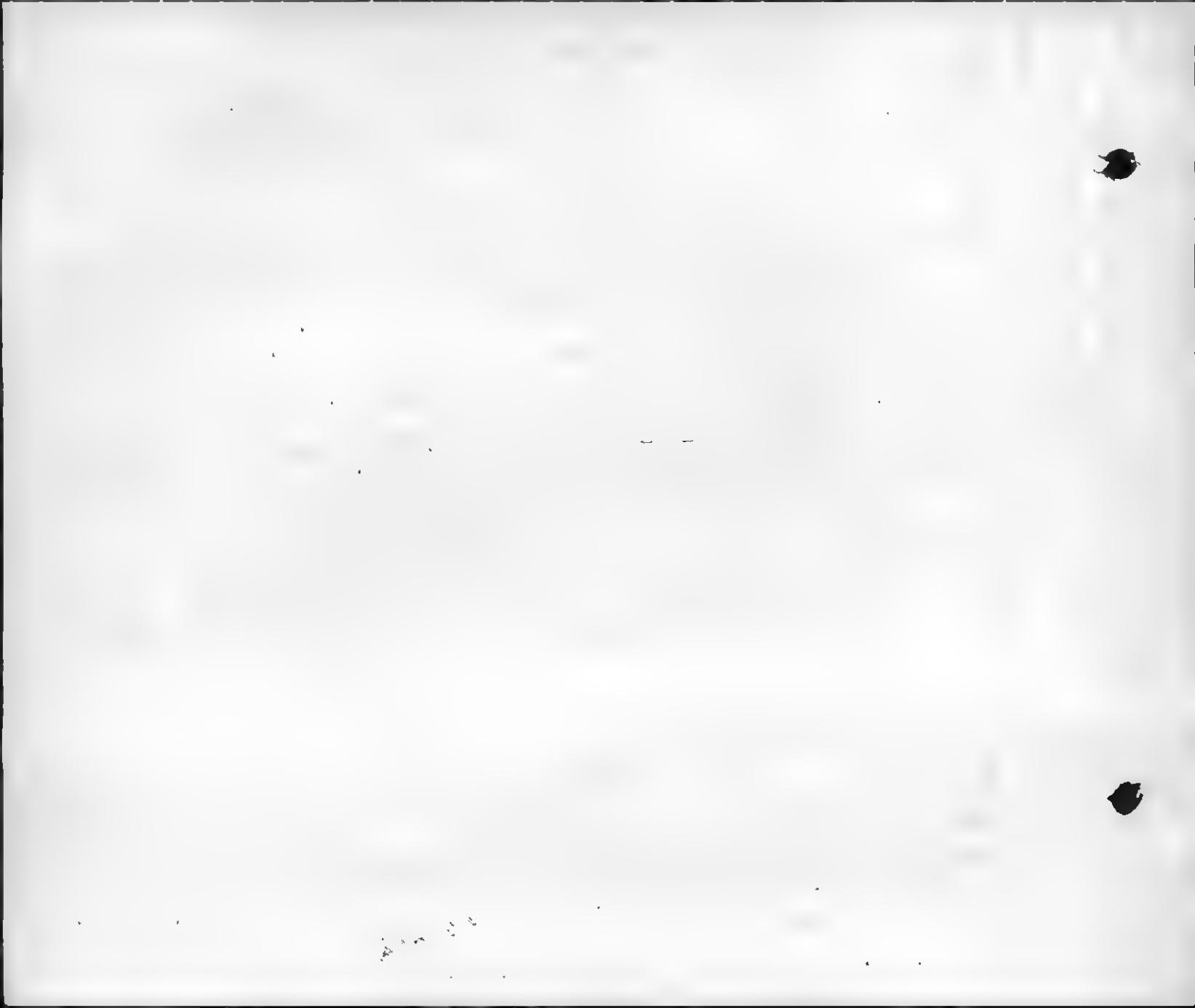
7346

CERTIFICATE OF DEATH

Reg. Dist. No.

07300

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport R # 2		b. COUNTY Washington	
c. LENGTH OF STAY IN 1b 10 Yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport R # 2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Doubt Road		d. STREET ADDRESS Doubt Road	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) GEORGE		First DANIEL	Middle DOUB
4. DATE OF DEATH June 14 1958		Month 19	Day Year
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Sept 8 1894		9. AGE (In years last birthday) 63 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Self Employed	11. BIRTHPLACE (State or foreign country) Fiddlersburg Wash. Co USA
12. CITIZEN OF WHAT COUNTRY USA			
13. FATHER'S NAME Abner F. Doub		14. MOTHER'S MAIDEN NAME Susanna G. Stockslager	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO 314-09-717	17. INFORMANT Mrs Mary K. Doub Williamsport R # 2
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		19. INTERVAL BETWEEN ONSET AND DEATH 5 min.	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b) DUE TO (c)		Coronary occlusion	
DUE TO Coronary arteriosclerosis		5 yrs	
DUE TO Generalized arteriosclerosis		Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> At work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 5, 1958, to June 14, 1958, that I last saw the deceased alive on June 14, 1958, and that death occurred at 3:50 PM, from the causes and on the date stated above		ADDRESS (Street, city or town, state) L. L. Packer Jr. 185 W. Washington 6/16/58	
ACTUAL SIGNATURE L. L. Packer Jr.		DATE SIGNED 6/16/58	
PHYSICIAN'S NAME (Type) L. L. Packer Jr.			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		22b. DATE THEREOF 6/17/58	22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery
22d. LOCATION (City, town, or county) Hagerstown Wash. Co		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.		24a. REC'D BY REGISTRAR DATE JUN 18 '58	24b. REGISTRAR'S SIGNATURE Audrey



07301

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

7347

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PHM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Washington MARYLAND		a. STATE Penna. b. COUNTY Franklin	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Rural, Sharpsburg		Waynesboro 75 X-	
c. LENGTH OF STAY IN lb		d. STREET ADDRESS	
3 Days		Wayne Bldg. Main & Potomac St.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF (Type or print)		First Harry	Middle R. Everly
Last		4. DATE OF DEATH	Month June / Day Year 1958
S. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Sept. 19, 1907
9. AGE (in years from birthday)		10. IF UNDER 1 YEAR Months 50 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)	
Meat sales man		Hagerstown, Md.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Charles E. Everly	
14. MOTHER'S MAIDEN NAME Ella M. Miller		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes World War II	
16. SOCIAL SECURITY NO. 214-09-7319		17. INFORMANT Mrs. Harry R. Everly, Waynesboro, Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 5 month	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.		My cerebral hemorrhage	
(b)		After induced Heart Failure	
DUE TO (c)		5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE <i>Dr. E. R. Miller</i>		DATE SIGNED <i>6/3/58</i>	
EXAMINER'S NAME (Type) <i>Dr. E. R. Miller Jr.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/4/1958	22c. NAME OF CEMETERY OR CREMATORIAL Rest Haven
22d. LOCATION (City, town, or county) Hagerstown		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur J. Grove</i>		24a. REC'D BY REGISTRAR DATE JUN 4 '58	24b. REGISTRAR'S SIGNATURE <i>Alv. L. L. L.</i>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7298

CERTIFICATE OF DEATH

07302

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 8 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WESTERN MARYLAND STATE HOSPITAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL, BALTIMORE 7	
3. NAME OF DECEASED (Type or print) CHARLES EDWARD FARLEY		4. DATE OF DEATH JUNE 12 1958	5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 6, 1880
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SUPERVISOR		10b. KIND OF BUSINESS OR INDUSTRY MENS CLOTHING	11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME CHARLES FREELOVE FARLEY	
14. MOTHER'S MAIDEN NAME NANCY McCULLOH		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO.		17. INFORMANT CHARLES EDWARD FARLEY/JR.	Address 5313 LIBERTY AVE. BALTIMORE 2 MD
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) RIGHT CORONARY THROMBOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. 260 (b) CORONARY ATHEROSCLEROSIS DUE TO (c) GENERALISED ARTERIOSCLEROSIS			
INTERVAL BETWEEN ONSET AND DEATH 5 DAYS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) DIABETES MELLITUS, FRACTURE OF RIGHT FEMUR			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from JUNE 4, 1958 to JUNE 12, 1958 , that I last saw the deceased alive on JUNE 12, 1958 , and that death occurred at 10.50 AM , from the causes and on the date stated above ADDRESS (Street, city or town, state) George Bercu, M.D. M.D. 1500 PENNSYLVANIA AVE. 6/12/58			
ACTUAL SIGNATURE DR. G. BERCY.		DATE SIGNED 6/12/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-12-58	22c. NAME OF CEMETERY OR CREMATORIUM Loudon Park Cemetery
22d. LOCATION (City, town, or county) Baltimore		(State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE E. Aremocot		23. ADDRESS 4600 Glenmont	24a. REC'D. BY REGISTRAR JUN 16 1958
24b. REGISTRAR'S SIGNATURE J. L. Clemon		DATE 6/16/58	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07303

7299 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Penna.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		b. COUNTY Franklin	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greencastle 75x.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. Co. Hospital		d. STREET ADDRESS S. Carlisle St. Ext.	
3. NAME OF DECEASED (Type or print)	First EZRA	Middle M.	Last FUNK
4. DATE OF DEATH	Month June	Day 10	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 3, 1886
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister		10b. KIND OF BUSINESS OR INDUSTRY Minister	
11. BIRTHPLACE (State or foreign country) near Chambersburg, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Benjamin Funk		14. MOTHER'S MAIDEN NAME Fannie Myers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 303-40-4050 17. INFORMANT Mrs. Bessie Funk Address Greencastle, Pa.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 177x DUE TO <i>Chronicoma of Prostate</i> INTERVAL BETWEEN ONSET AND DEATH 3 yrs -			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept</u> , 1958, to <u>10 Jun</u> , 1958, that I last saw the deceased alive on <u>10 Jun 58</u> , 1958, and that death occurred at <u>415</u> M, from the causes and on the date stated above. ACTUAL SIGNATURE <u>Paul F. Webster</u> ADDRESS (Street, city or town, state) <u>27 South Carlisle St.</u> DATE SIGNED <u>6/11/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 14/58	
22c. NAME OF CEMETERY OR CREMATORIAL Strinestown Cem.		22d. LOCATION (City, town, or county) (State) Strinestown, Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. E. Munich - Greencastle, Pa.</u>		24a. REC'D BY REGISTRAR <u>Greencastle</u> DATE <u>6/11/58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Greencastle</u>	

HOSPITAL ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page _____ may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

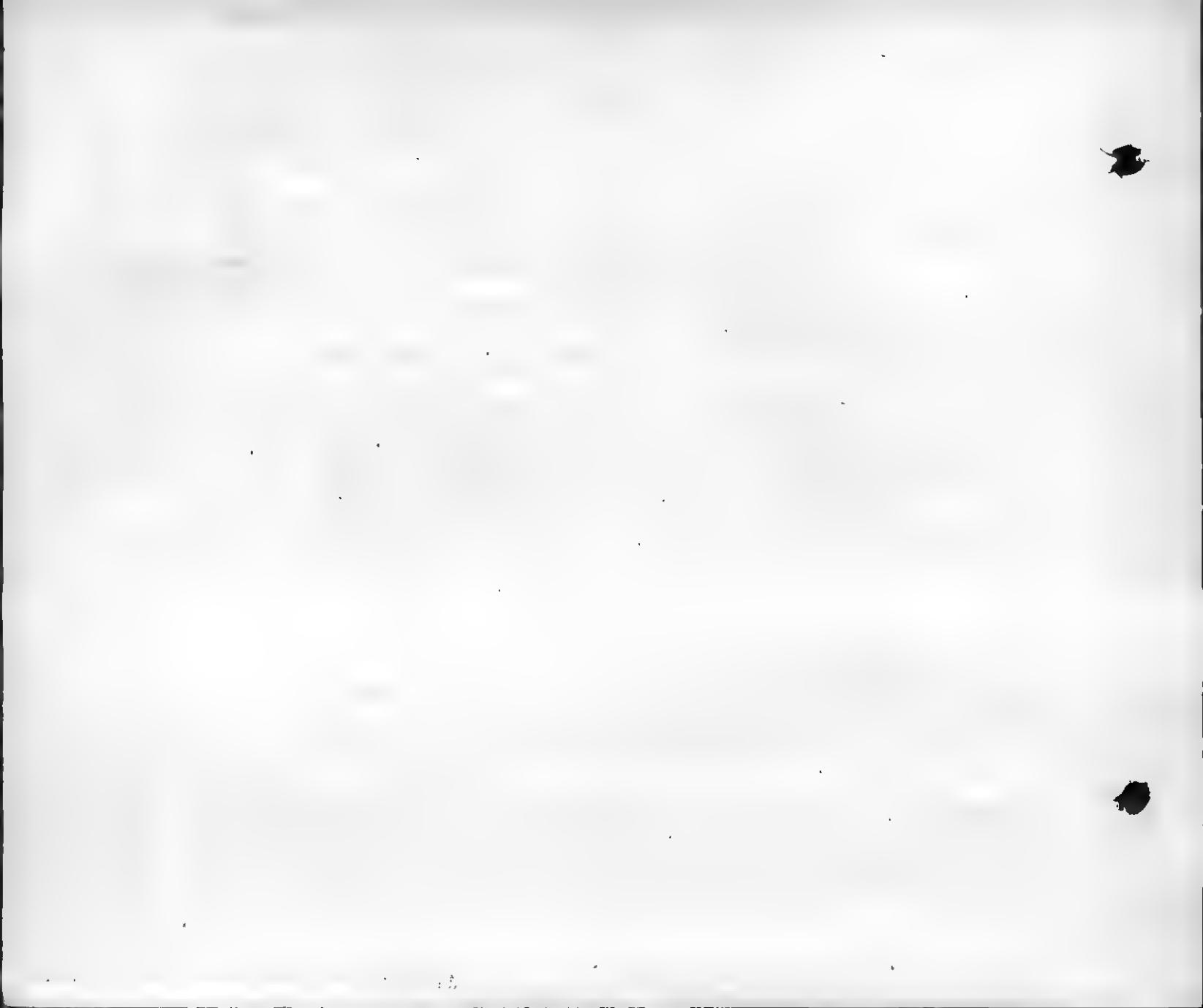
07304

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7300 CERTIFICATE OF DEATH

Reg. Dist. No. _____

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE L Maryland		b. COUNTY ashington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 43 East Washington St				d. STREET ADDRESS #3 East Washington St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) SYLVESTER LARTIN FUNK		First	Middle	Lost	4. DATE OF DEATH June 11 1958	Month	Day	Year
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH June 5 1877	9. AGE (In years last birthday) 81 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner & operator of Business College		10b. KIND OF BUSINESS OR INDUSTRY ht. Morris Ogle Co		11. BIRTHPLACE (State or foreign country) Ill		12. CITIZEN OF WHAT COUNTRY USA		
13. FATHER'S NAME Samuel M. Funk		14. MOTHER'S MAIDEN NAME Susan Maysilles						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO -----		17. INFORMANT Miss Zanerian Funk 43 E. Washington		Address Hagerstown		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) myocardial Failure						INTERVAL BETWEEN ONSET AND DEATH 1 month		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Generalized Arteriosclerosis								
(c) DUE TO 10 yrs								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from Oct 1 1956 to June 11 1958 that I last saw the deceased alive on June 9 1958 , and that death occurred at 9:10 P.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state) Robert V. Campbell M.D. 145 W Washington St Hagerstown Md.		DATE SIGNED 6/13/58		
ACTUAL SIGNATURE Robert V. Campbell M.D.								
PHYSICIAN'S NAME (Type) Robert V. Campbell								
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 6/14/58		22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Wash. Co. Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffran Hagerstown Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE JUN 16 '58		24b. REGISTRAR'S SIGNATURE Alfred L. Smith		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7348

CERTIFICATE OF DEATH

Reg. Dist. No. 07305

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland		b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hagerstown		c. LENGTH OF STAY IN 1b 6 yrs., 1 mo.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Westminster		d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) Furney & Needy Memorial Home						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (type or print) John		First	Middle	Last	4. DATE OF DEATH Jun. 23, 1955	Month	Day	Year	
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 21, 1873	9. AGE (In years last birthday) 74 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Jasper Garner				14. MOTHER'S MAIDEN NAME Hannah Yon					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mr. Ralph L. Garner, Owings Mills, Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				INTERVAL BETWEEN ONSET AND DEATH days			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Baltimore		(County)	(State)
21. I certify that I attended the deceased from <u>Feb. 10, 1955</u> to <u>June 28, 1955</u> , that I last saw the deceased alive on <u>June 28, 1955</u> , and that death occurred at <u>211 M.</u> from the causes and on the date stated above.						ADDRESS (Street, city or town, state) Baltimore			
ACTUAL SIGNATURE G. W. Lelan						DATE SIGNED 6/28/55			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 1, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Meadow Branch Cemetery		22d. LOCATION (City, town, or county) Westminster, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Merwyn C. Fuss C. O. Fuss & Son		ADDRESS Towson, Maryland		24a. REC'D BY REGISTRAR DATE JUL 3 '58		24b. REGISTRAR'S SIGNATURE Albert E. Smith			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

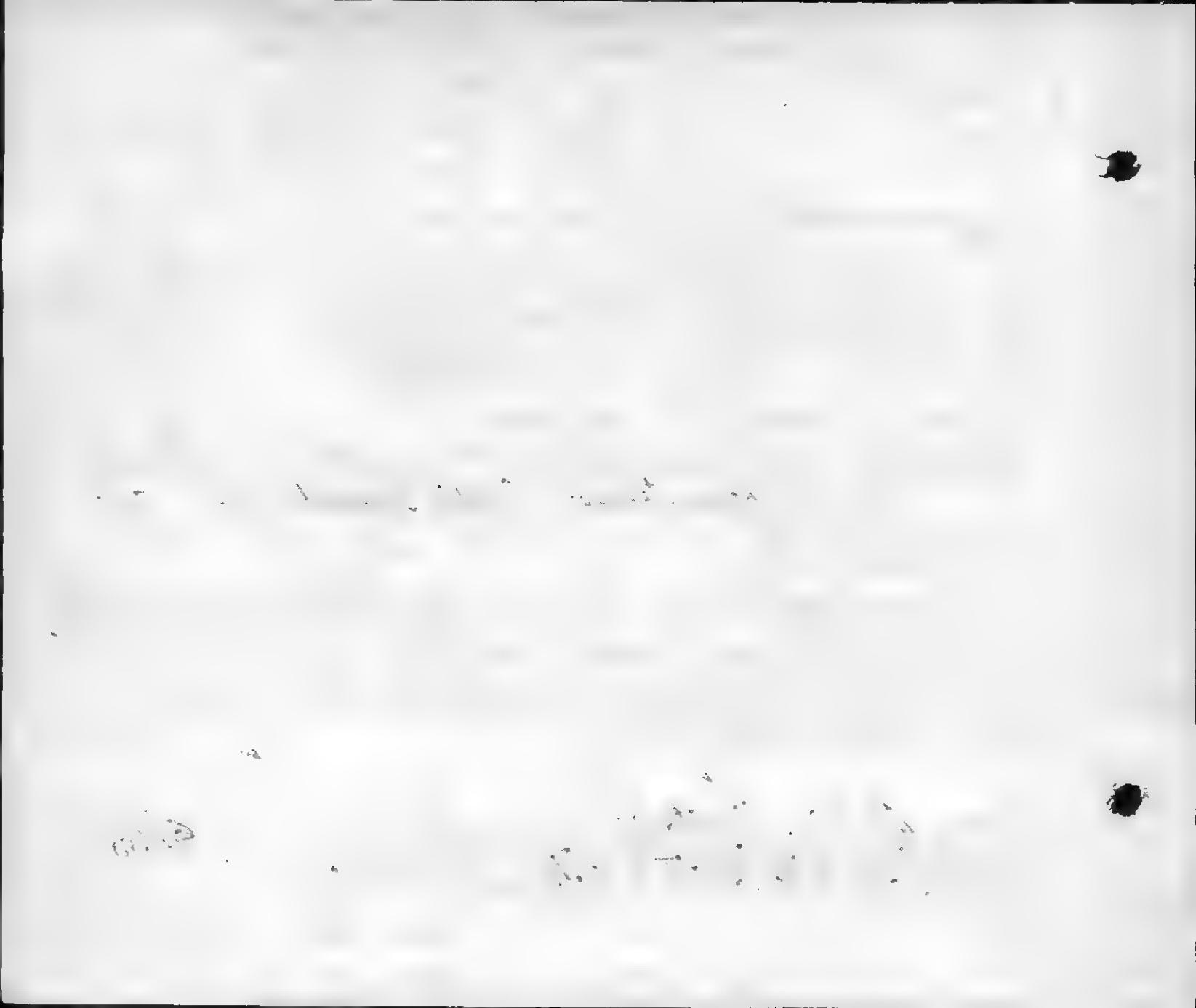
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07306

Reg. Dist. No.

7301

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
WASHINGTON		a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb	
HAGERSTOWN		104 YEARS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
26 WEST BALTIMORE ST.			
3. NAME OF DECEASED (Type or print)		First	Middle
WOODROW		JAMES	GRIFFITH
4. DATE OF DEATH		Month	Day Year
ABOUT JUNE - 1 - 1958			
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
MALE		WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH		9. AGE (in years, last birthday)	
NOV. 26-1912		45 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
TRACKMAN		B&O R.R. CO.	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
BOONSBORO WASH. CO. MD. U.S.A.			
13. FATHER'S NAME		14. MOTHER'S MOTHER'S NAME	
DAVID L. GRIFFITH		TIMMIE GREENA WALT.	
15. IF DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
YES		W.W. 2	
17. INFORMANT		Address	
MRS. WHEELER HAUPT		BOONSBORO MD. R. 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypertensive Cardio Vascular Dis.</i> DUE TO 245			
Conditions, if any, which gave rise to immediate cause (b) DUE TO			
(a), stating the underlying cause last. (c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Dr. E.W. Dutton Jr.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>Dr. E.W. Dutton Jr.</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>JUNE 3, 1958</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>BOONSBORO CEMETERY</i>		22d. LOCATION (City, town, or county) (State) <i>BOONSBORO WASH. CO. MD.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Best Funeral Home Boonsboro Md.</i>		ADDRESS	
		24a. REC'D BY REGISTRAR <i>DATE JUN 5 '58</i>	
		24b. REGISTRAR'S SIGNATURE <i>DeLoach</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

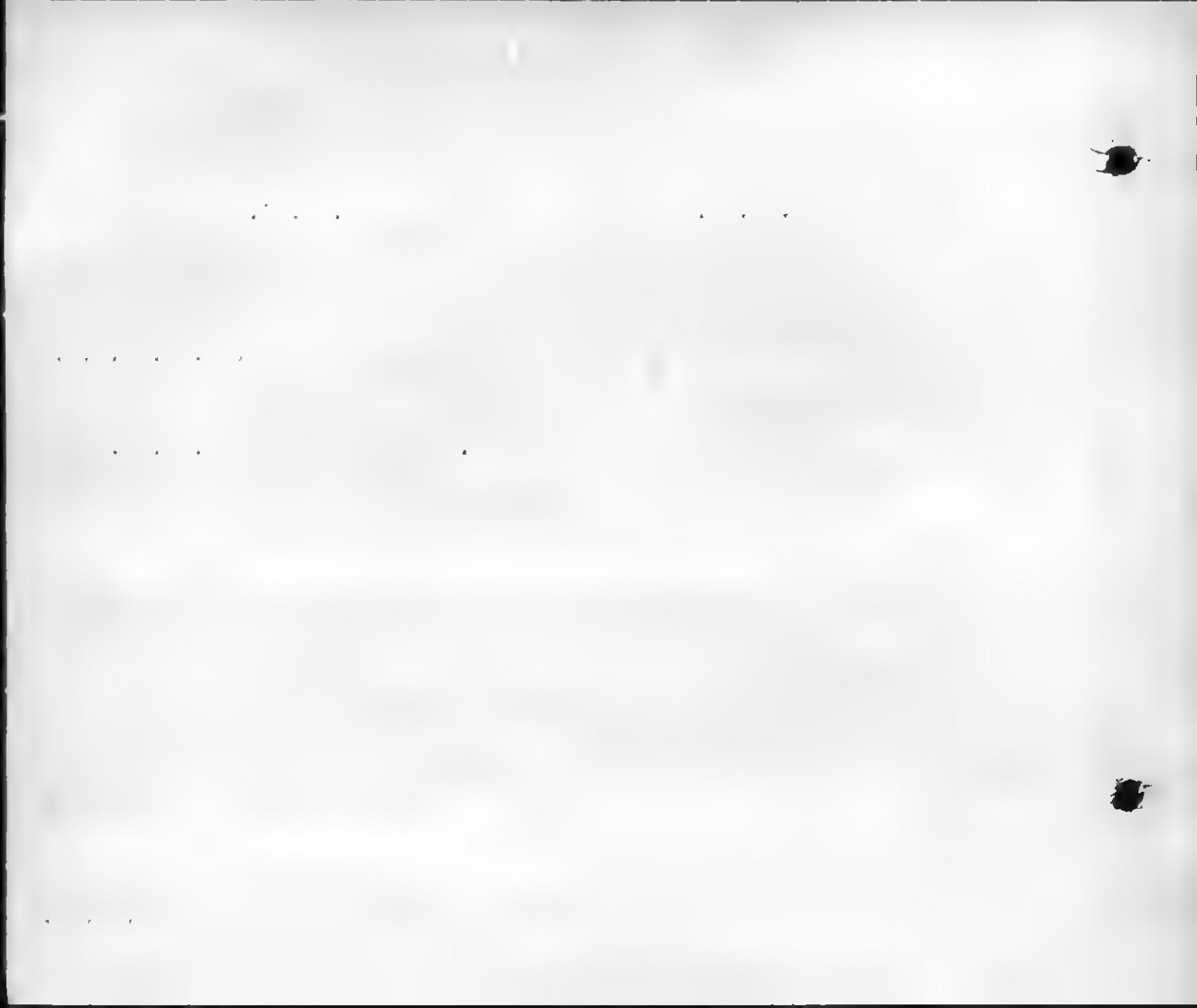
7349 CERTIFICATE OF DEATH

07307

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY WASHINGTON		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MARYLAND		b. COUNTY WASHINGTON					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GAPLAND		c. LENGTH OF STAY IN 1b 40 YEARS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GAPLAND		d. STREET ADDRESS GAPLAND WASH.CO.MD.					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GAPLAND WASH.CO.MD.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)	First BESSIE	Middle N	Last HAGAN	4. DATE OF DEATH	Month JUNE	Day 22	Year 1958				
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 7 1908	9. AGE (In years last birthday) 50	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE KEEPER		10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) CHESTNUT GROVE WASH.CO.MD. U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME SAMUEL HOLMES		14. MOTHER'S MAIDEN NAME ALVIRTA HOLMES		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) NO		16. SOCIAL SECURITY NO. NONE					
17. INFORMANT RALPH A. HAGAN GAPLAND WASH.CO.MD.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)		19. INTERVAL BETWEEN ONSET AND DEATH 2 yrs.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1-2 , 1958, to July 2 , 1958, that I last saw the deceased alive on July 2 , 1958, and that death occurred at 10 P.M. from the causes and on the date stated above ACTUAL SIGNATURE <i>John H. Bandy</i>		M.D.		ADDRESS (Street, city or town, state) Baltimore Md.		DATE SIGNED 6-23-58					
22a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		22b. DATE THEREOF JUNE 25 1958		22c. NAME OF CEMETERY OR CREMATORIUM ROHRERSVILLE CEMETERY		22d. LOCATION (City, town, or county) ROHRERSVILLE WASH.CO.MD.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>John H. Bandy Sr. Baltimore Md.</i>		ADDRESS <i>John H. Bandy Sr. Baltimore Md.</i>		24a. REC'D BY REGISTRAR DATE JUL 1 '58		24b. REGISTRAR'S SIGNATURE <i>Albert Leach</i>					



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

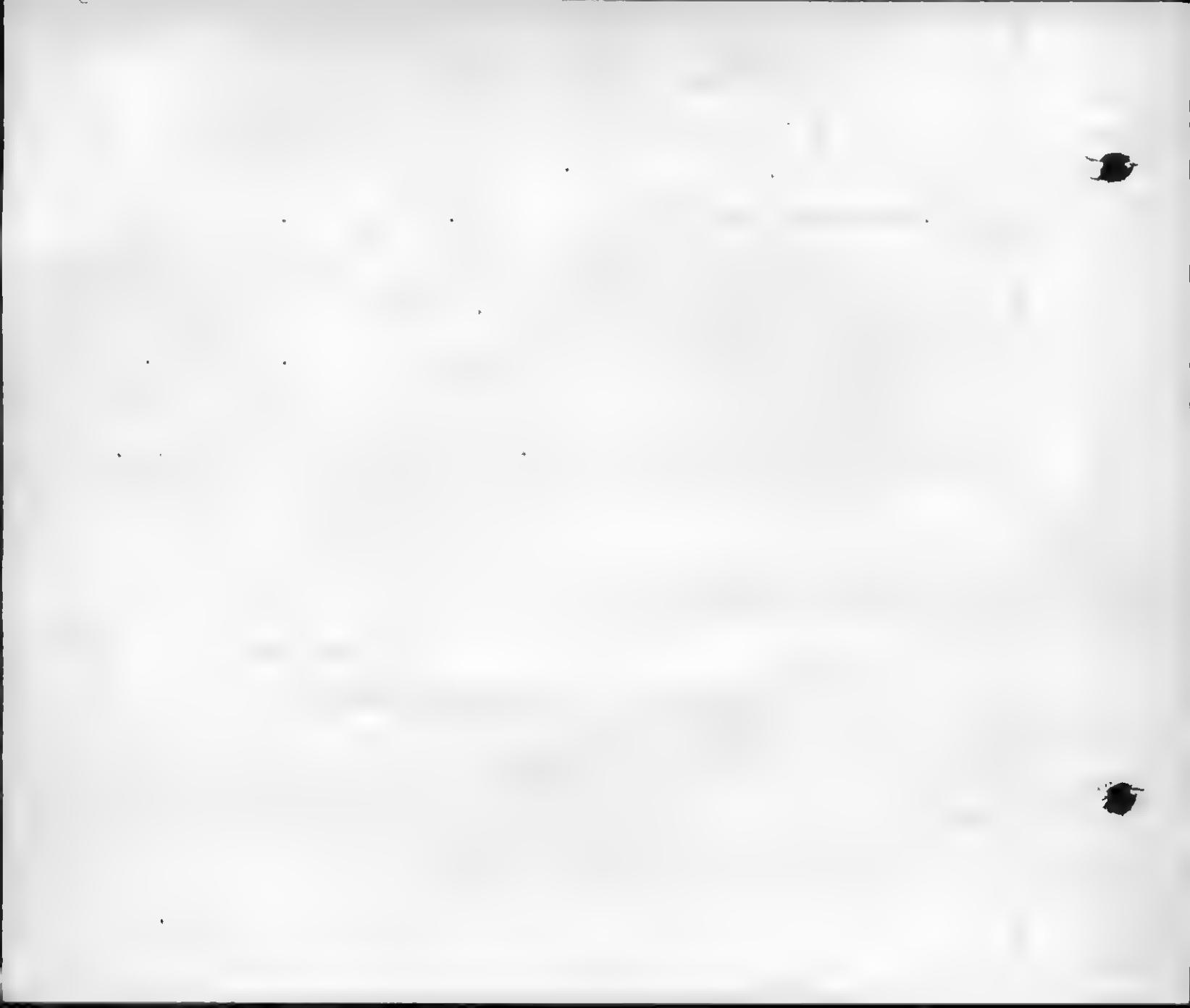
07308

7350

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport Md.		c. LENGTH OF STAY IN 1b 85 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION #9 N. Artizan Street		e. STREET ADDRESS #9 N. Artizan St.	
3. NAME OF DECEASED (Type or print) Albert Stroble		4. DATE OF DEATH June	Month Day Year 1 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 18 1872
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min. 8 13	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retail Merchant & Butcher		10b. KIND OF BUSINESS OR INDUSTRY Store	11. BIRTHPLACE (State or foreign country) Williamsport Md.
12. CITIZEN OF WHAT COUNTRY U. S. A.		13. FATHER'S NAME Martin Van Buran Harsh	
14. MOTHER'S MAIDEN NAME Emily Catherine Snyder		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO None		17. INFORMANT Mrs. Sarah Lemen Williamsport, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 4 yrs.	
4 a.c.c DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 5/7, 1953, to 1/1, 1958, that I last saw the deceased alive on 26 May, 1958, and that death occurred at 97 W. Patonae Street, Williamsport, Md., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 28 W. Patonae Street 2 June 58	
ACTUAL SIGNATURE Paul HAAK, M.D.		DATE SIGNED 2 June 58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 3 1958	22c. NAME OF CEMETERY OR CREMATORIUM Riverview Cemetery
23. FUNERAL DIRECTOR'S SIGNATURE Albert Leaf Williamsport, Md.		24a. REC'D BY REGISTRAR DATE JUN 3 '58	24b. REGISTRAR'S SIGNATURE A. Leach



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

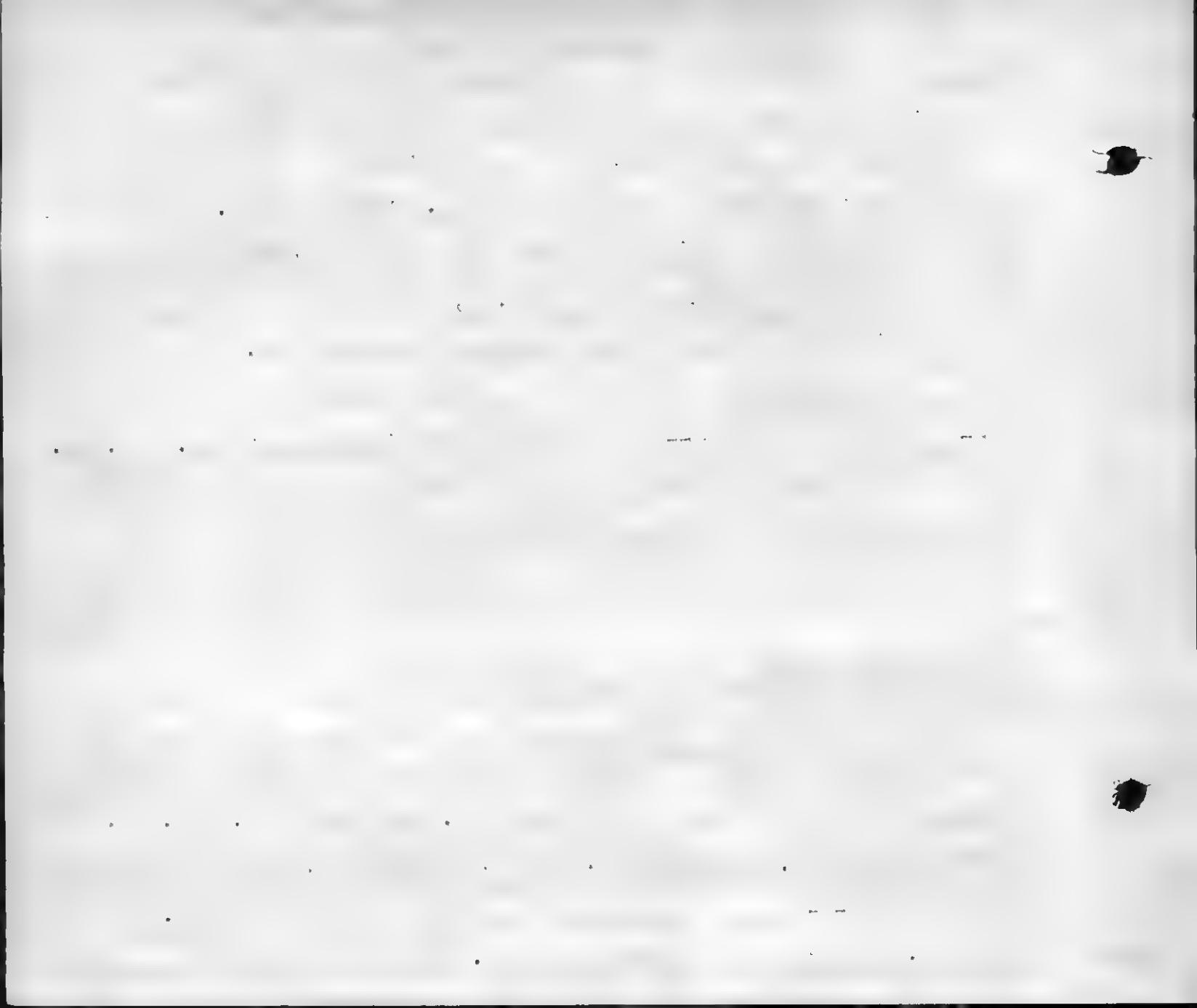
7302

CERTIFICATE OF DEATH

Reg. Dist. No.

07309

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Ill b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 42 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Martin Manor Rest Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chicago	
3. NAME OF DECEASED (Type or print) Florence		First Middle Virginia	Last Hemphill
4. DATE OF DEATH June		Month 4	Day Year 1958
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> Feb. 1, 1876
8. AGE (In years last birthday) 82 yrs.		9. IF UNDER 1 YEAR Months Days	10. IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Near Sharpsburg Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Jack Bowers		14. MOTHER'S MAIDEN NAME Mary Riley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ---		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Russell Hemphill		Address Security Rd. Hagerstown Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 44-0-0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 year ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, M., from the causes and on the date stated above. ACTUAL SIGNATURE <i>Philip J. Hirshman</i>		ADDRESS (Street, city or town, state) M.D. 159 W. Washington St. Hagerstown Md. DATE SIGNED 6/6/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-7-58	
22c. NAME OF CEMETERY OR CREMATORIAL Rest Haven Cemetery		22d. LOCATION (City, town, or county) Hagerstown Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son Hagerstown Md.		24a. REC'D BY REGISTRAR DATE JUN 9 '58	
VS A15 (4) 15M 9/55		24b. REGISTRAR'S SIGNATURE <i>Al. J. Hirshman</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

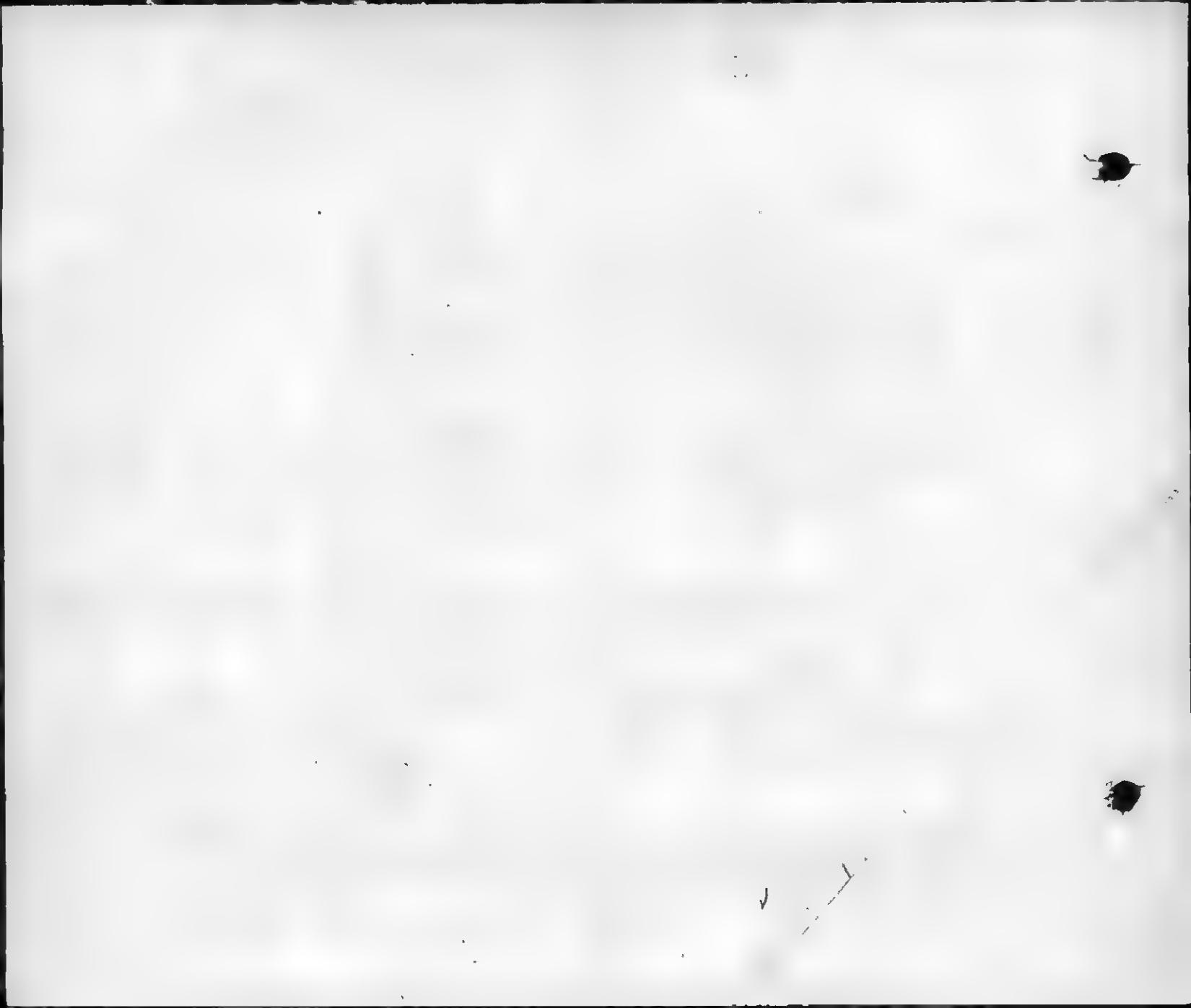
07310

7303

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 429 Salem Ave.			d. STREET ADDRESS 429 Salem Ave.		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First GUY	Middle HAYES	Last HENDRICKSON	4. DATE OF DEATH June 9 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH March 9, 1884	9. AGE (In years from last birthday) 74 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer (Locomotive)			10b. KIND OF BUSINESS OR INDUSTRY Railroad	11. BIRTHPLACE (State or foreign country) Penns.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-24-5564		17. INFORMANT Mrs. Doris Henson 429 Salem Ave. Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)					
INTERVAL BETWEEN ONSET AND DEATH 7 Day					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 6/19/58	
20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____, 19_____. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED					
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Ralph F. Young M.D.					
101 E. Potomac St. Williamsport, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/13/58		22c. NAME OF CEMETERY OR CREMATORIAL Rest Haven Cemetery	
22d. LOCATION (City, town, or county) Hagerstown		(State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Inc.			ADDRESS 1601 Penna. Ave. Hagerstown, Md.		
VS A15 (4) ISM 9/55			24a. REC'D BY REGISTRAR JUN 16 1958		
			24b. REGISTRAR'S SIGNATURE John C. Johnson		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 1-17-1958 7-11-58 pt
7304 CERTIFICATE OF DEATH

Reg. Dist. No. 07311

1. PLACE OF DEATH a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)		
Washington		Hagerstown		2		a. STATE Maryland		
MARYLAND						b. COUNTY Washington		
						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		
						Baltimore		
						d. STREET ADDRESS 1000 E. 36th Street		
						IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
						Faherty-Keady Memorial Home		
3. NAME OF DECEASED (Type or print)		First William	Middle Henry	Last Hobson	4. DATE OF DEATH	Month June	Day 7	Year 1958
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH April 5, 1882	9. AGE (In years last birthday) 76 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Laundry		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME William Henry Hobson				14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO 213-01-8373A		17. INFORMANT Mrs. Blair W. Rairigh		Address Baltimore 12 107 Croyden Road		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 440A Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Vascular Disease				INTERVAL BETWEEN ONSET AND DEATH 10/2-10		
		(c)						
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County)	(State)	
19								
21. I certify that I attended the deceased from June 3, 1958, to June 7, 1958, that I last saw the deceased alive on June 7, 1958, and that death occurred at 671 M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Baltimore				DATE SIGNED 6/7/58		
ACTUAL SIGNATURE G. W. HeVan								
PHYSICIAN'S NAME (Type)								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 10, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Druid Ridge		22d. LOCATION (City, town, or county) Pikesville, Maryland		
						(State)		
23. FUNERAL DIRECTOR'S SIGNATURE Burgee Funeral Home		ADDRESS 3631 Falls Road		24a. RECD BY REGISTRAR DATE JUN 10 '58		24b. REGISTRAR'S SIGNATURE Burgee		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7305

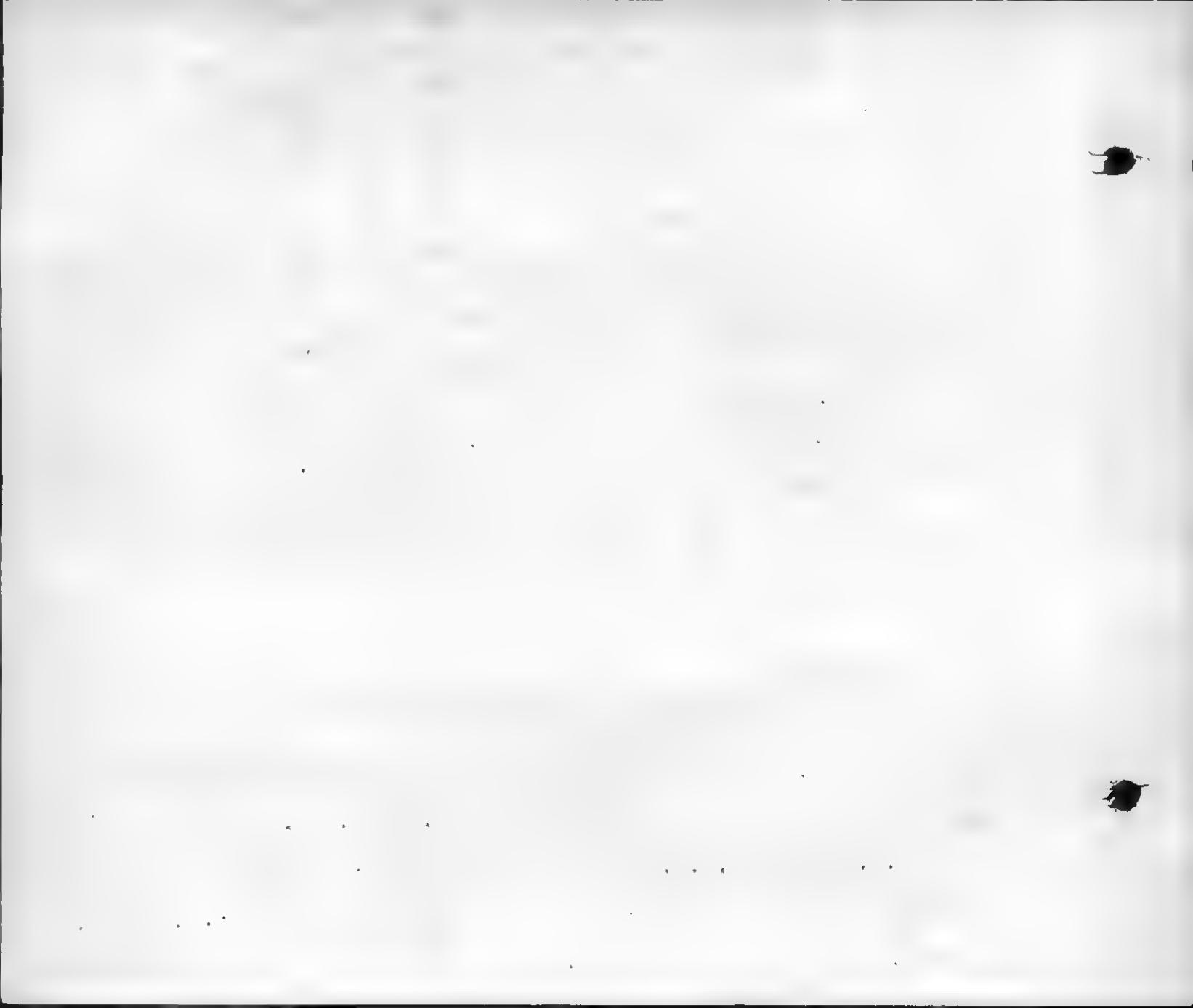
CERTIFICATE OF DEATH

Reg. Dist. No. 87312

HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if residence before admission) a. STATE Maryland		b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 30 Yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		d. STREET ADDRESS 1051 Pope Ave		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1051 Pope Ave				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		EX		
3. NAME OF DECEASED (Type or print) CORA		First	Middle	Last	4. DATE OF DEATH June 26 1958	Month	Day	Year
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 14 1883		9. AGE (in years last birthday) 74 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) State Line Franklin Co		12. CITIZEN OF WHAT COUNTRY? Pa USA		
13. FATHER'S NAME John H. Beard		14. MOTHER'S MAIDEN NAME Elizabeth Weaver						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or No or Unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT Thos H. Hoffmaster 1051 Pope Ave		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 260X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		DUE TO (b) Stenocardiac Heart Disease		Hagerstown Md. Cardiac failure - Congestive		INTERVAL BETWEEN ONSET AND DEATH 4 weeks		
DUE TO (c) Diabetes mellitus								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic pylonephritis								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>July 14</u> , 1952 to <u>June 26</u> , 1958, that I last saw the deceased alive on <u>June 20</u> , 1958, and that death occurred at <u>3:00 PM</u> , from the causes and on the date stated above						ADDRESS (Street, city or town, state)		
ACTUAL SIGNATURE <u>L. L. Packer, Jr. M.D.</u>		M.D.		145 W. Wash. St.		DATE SIGNED 6/27/58		
PHYSICIAN'S NAME (Type) L. L. Packer, Jr. M.D.				Hagerstown, Maryland				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/29/58		22c. NAME OF CEMETERY OR CREMATORIUM Rest Haven Cemetery		22d. LOCATION (City, town, or county) Hagerstown Wash. Co. Md. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Cofman Hagerstown Md.		ADDRESS		24a. REC'D BY REGISTRAR JUN 30 1958		24b. REGISTRAR'S SIGNATURE John P. Packer		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07313

7351

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport rd.		c. LENGTH OF STAY IN lb 30 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport		d. STREET ADDRESS 14 Conococheague St.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 14 Conococheague St.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) CLARA		First	Middle	Last	4. DATE OF DEATH HUFF	Month	Day	Year
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 18 1980	9. AGE (In years last birthday) 78	10. IF UNDER 1 YEAR Months 3	11. IF UNDER 24 HRS Days 19	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY: USA		
13. FATHER'S NAME Columbus Hanes		14. MOTHER'S MAIDEN NAME Catherine Ayers						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT Mrs. Wanda Davis		18. ADDRESS 14 Conococheague St Williamsport Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 Day		
19. MEDICAL CERTIFICATION		20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Williamsport		(County) (State)
21. I certify that I attended the deceased from _____ to _____, that I last saw the deceased alive on _____, and that death occurred at _____, M., from the causes and on the date stated above ADDRESS (Street, city, or town, state)								DATE SIGNED
ACTUAL SIGNATURE <i>Richard J. Spangler</i>		M.D. <i>Richard J. Spangler</i>						
PHYSICIAN'S NAME (Type) <i>Richard J. Spangler</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 10-58		22c. NAME OF CEMETERY OR CREMATORIUM Greenlawn Cemetery		22d. LOCATION (City, town, or county) Williamsport		(State) Ind.
23. FURNITURE DIRECTOR'S SIGNATURE <i>Albert K. Stoeck</i>		ADDRESS Williamsport Md		24a. REC'D BY REGISTRAR DATE JUN 11 '58		24b. REGISTRAR'S SIGNATURE <i>W. L. Schenck</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be used for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7306 CERTIFICATE OF DEATH

Reg. Dist. No. 07314

1. PLACE OF DEATH a. COUNTY WASHINGTON		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MARYLAND		b. COUNTY WASHINGTON					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN lb MIDDLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MILITIA - RURAL							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON COUNTY HOSPITAL		1st STREET ADDRESS Boonsboro MD. R-2.		4. DATE OF DEATH JUNE - 2 - 1958		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) C. ROVER		First C. MIDDLE LEVI		Lost		Month	Day	Year			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH APRIL - 14 - 1884		9. AGE (in years lost birthday) 74 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED CARPENTER		10b. KIND OF BUSINESS OR INDUSTRY GENERAL BUILDING		11. BIRTHPLACE (State or foreign country) AKRON OHIO		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME JAMES HURLEY		14. MOTHER'S MAIDEN NAME IDA SWOPE		15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input type="checkbox"/> NO		16. SOCIAL SECURITY NO.		17. INFORMANT MRS. VADA S. HURLEY		Address Boonsboro MD. R-2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 440.1 Hypertensive cardiovascular disease		DUE TO		INTERVAL BETWEEN ONSET AND DEATH 1 year							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from May 175 , 1958, to June 2 , 1958, that I last saw the deceased alive on May 31 , 1958, and that death occurred at 5 A.M. from the causes and on the date stated above.											
ACTUAL SIGNATURE G. White Van						ADDRESS (Street, city or town, state) Boonsboro				DATE SIGNED 6/3/58	
PHYSICIAN'S NAME (Type)											
22a. BURIAL, CREMATON, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JUNE 4-1958		22c. NAME OF CEMETERY OR CREMATORIUM BOONSBORO CEMETERY		22d. LOCATION (City, town, or county) Boonsboro WASH. Co. MD.					
23. FUNERAL DIRECTOR'S SIGNATURE Best Funeral Home		ADDRESS		24a. REC'D BY REGISTRAR JUN 5 '58		24b. REGISTRAR'S SIGNATURE DeLoach					



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

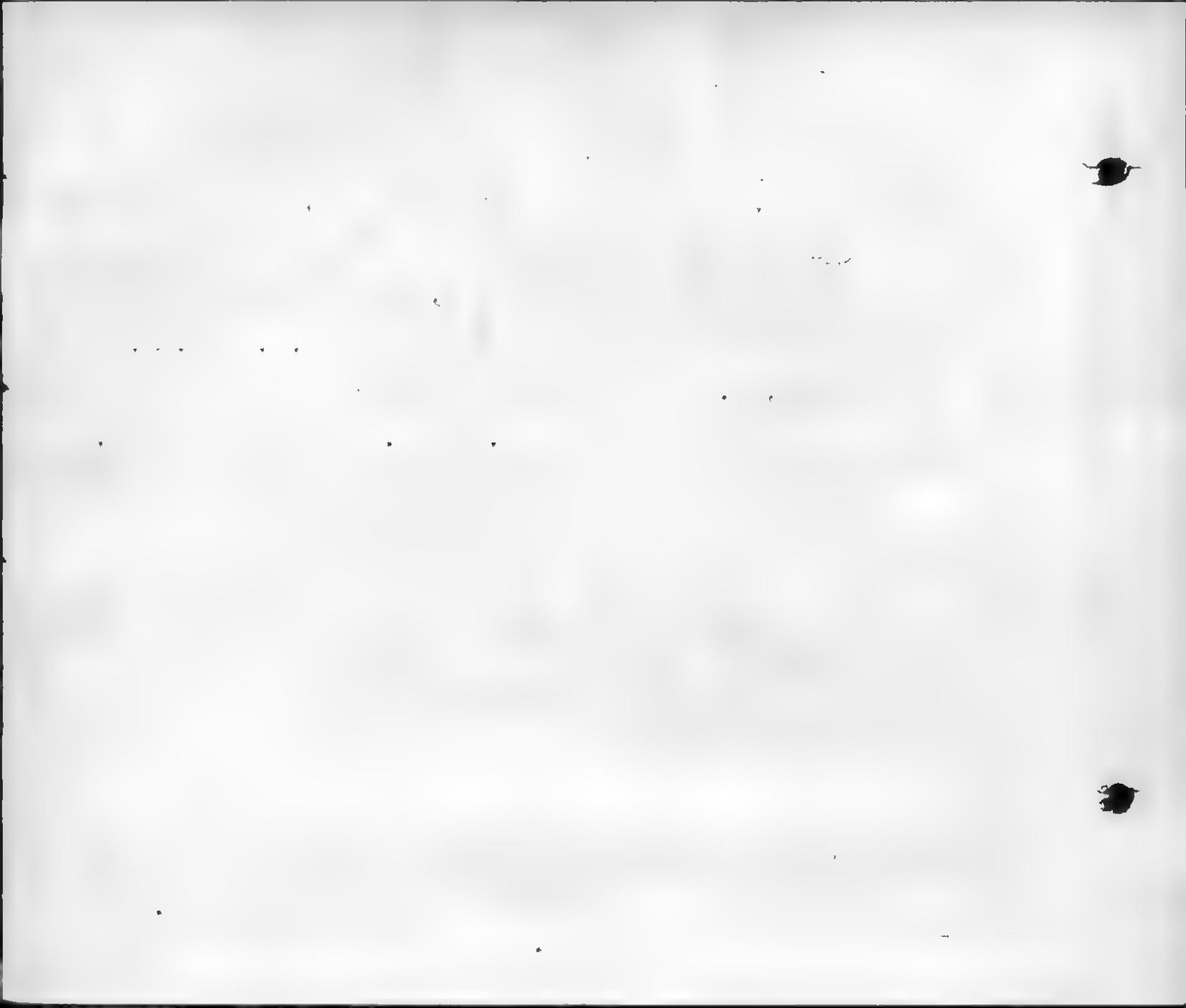
7307

CERTIFICATE OF DEATH

07315

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Washington				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 26 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		d. STREET ADDRESS 1122 Hamilton Blvd.				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1122 Hamilton Blvd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)	First RICHARD	Middle HANN	Last JOHNSON	4. DATE OF DEATH	Month June	Day 30	Year 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH April 12, 1878	9. AGE (In years lost birthday) 80 yrs.	10. IF UNDER 1 YEAR Months 2	11. IF UNDER 24 HRS Days 18	Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard		10b. KIND OF BUSINESS OR INDUSTRY Aircraft Plant		11. BIRTHPLACE (State or foreign country) Lambertsville, N. J.		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Jacob Johnson, Sr.				14. MOTHER'S MAIDEN NAME Ella ?						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No		16. SOCIAL SECURITY NO		17. INFORMANT		Address Mrs. Edith M. Johnson Hagerstown, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease INTERVAL BETWEEN ONSET AND DEATH Months. 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Generalized arteriosclerosis. 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 29, 1958 to June 30, 1958 , that I last saw the deceased alive on June 29, 1958 , and that death occurred at 12:15 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>R. A. Bell</i>								ADDRESS (Street, city or town, state) 119 North Potomac Street		DATE SIGNED 7/1/58
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/3/1958		22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery		22d. LOCATION (City, town, or county) Hagerstown, Md.		(State)		
22e. FUNERAL DIRECTOR'S SIGNATURE Suter-Houzer Funeral Home		ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR JUL 3 1958		24b. REGISTRAR'S SIGNATURE <i>Alfred E. D. Burch</i>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

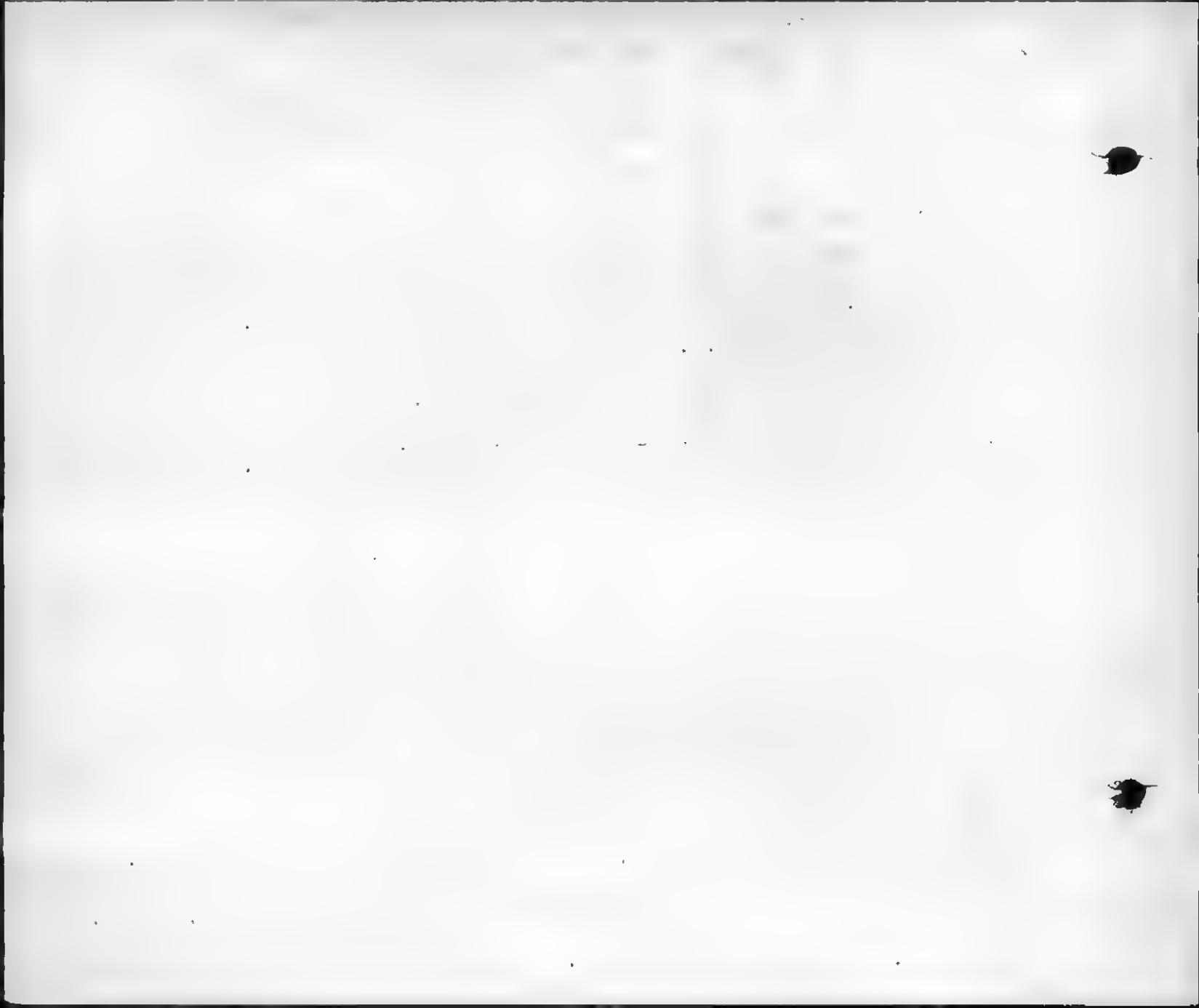
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7308 CERTIFICATE OF DEATH

07316

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb 3 Days		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland		b. COUNTY Washington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sh. County Hospital		d. STREET ADDRESS 13 So Mulberry St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) HARRY		First	Middle BURKE	Lost	4. DATE OF DEATH June 19 1958	Month June	Day 19	Year 19			
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Feby 11 1897	9. AGE (In years last birthday) 61 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Hours 0				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Car Inspector B & O R.R.		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Clear Spring Wash Co		12. CITIZEN OF WHAT COUNTRY USA							
13. FATHER'S NAME Harvey B. Jones		14. MOTHER'S MAIDEN NAME Loula E. Spielman		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 314-09-3577		17. INFORMANT Mrs Josie S. Jones		Address 13 So Mulberry St Hagerstown Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 162.1		DUE TO <i>Carcinoma of Bronchus</i>		INTERVAL BETWEEN ONSET AND DEATH 18 mo							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)									
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D. 159 W. Washington St., Hagerstown, Md.							
20f. (City or town) Hagerstown				(County) Washington Co.							
				(State) Md.							
21. I certify that I attended the deceased from 6/19/58 to 6/19/58 that I last saw the deceased alive on June 19, 1958 , and that death occurred at 6:00 P.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state) M.D. 159 W. Washington St., Hagerstown, Md.							
ACTUAL SIGNATURE <i>Philip J. Hirshman</i>				DATE SIGNED 6/20/58							
PHYSICIAN'S NAME (Type) Philip J. Hirshman, M.D.		159 W. Washington St., Hagerstown, Md. 6/20/58									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/23/58		22c. NAME OF CEMETERY OR CREMATORY Hest Haven Cemetery		22d. LOCATION (City, town, or county) Hagerstown Wash Co. Md.					
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.		ADDRESS		24a. REC'D BY REGISTRAR JUN 26 '58		24b. REGISTRAR'S SIGNATURE Alt. esch					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7352

CERTIFICATE OF DEATH

07317

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY

Washington

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Mr. Downsville, Md.

c. LENGTH OF STAY IN 1b

2 hrs.

d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

Potomac River

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

a. STATE

Maryland

b. COUNTY

Washington

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Hagerstown-Route # 6

d. STREET ADDRESS

Showalter Road

e. IS RESIDENCE
ON A FARM
YES NO

3. NAME OF
DECEASED
(Type or print)

First
"ILLIAJ.

Middle
HENRY

LAST
JONES

4. DATE
OF
DEATH

Month
June

Day
14, 1958
Year

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

Sept. 21, 1886

9. AGE (In years
last birthday)

71

10. IF UNDER 1 YEAR

IF UNDER 24 HRS

Months Days Hours Min

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Gardener

10b. KIND OF BUSINESS OR INDUSTRY

Self-employed

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY

USA

13. FATHER'S NAME

John W. Jones

14. MOTHER'S MAIDEN NAME

Adeline Rennell

15. WAS DECEASED EVER IN U. S. ARMED FORCES?

(Yes, no, or unknown) (If yes, give war or date of service)

No

16. SOCIAL SECURITY NO.

214-09-2193A

17. INFORMANT

Mrs. Thelma Jones-Hagers, R. #6

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

Part I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

11/20/00

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b)

DUE TO

(c)

Coronary occlusion

INTERVAL BETWEEN
ONSET AND DEATH

sudden

Arteriosclerotic heart disease

months

Angina, chronic

hours

MEDICAL CERTIFICATION

19. WAS AUTOPSY
PERFORMED?
YES NO

20a. ACCIDENT WAS UNDERLYING OR
CONTRIBUTING CAUSE OF DEATH
(If either, notify medical examiner)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour o. m. 19
p. m.

20d. INJURY OCCURRED
While at work Not while
at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from April 7, 1958, to June 2, 1958, that I last saw the deceased
alive on June 2, 1958, and that death occurred at 6:30 P.M. from the causes and on the date stated above.

ACTUAL
SIGNATURE

Philip J. Hirshman, M.D. 159 W. Washington St., Hagerstown, Maryland

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

6-17-58

22c. NAME OF CEMETERY OR CEMETORY

Bethel Cemetery

22d. LOCATION (City, town, or county)

(State)

Cherry Run-Organ Co., Va.

23. FUNERAL DIRECTOR'S SIGNATURE

Andrew K. Coffman-Hagerstown, Maryland

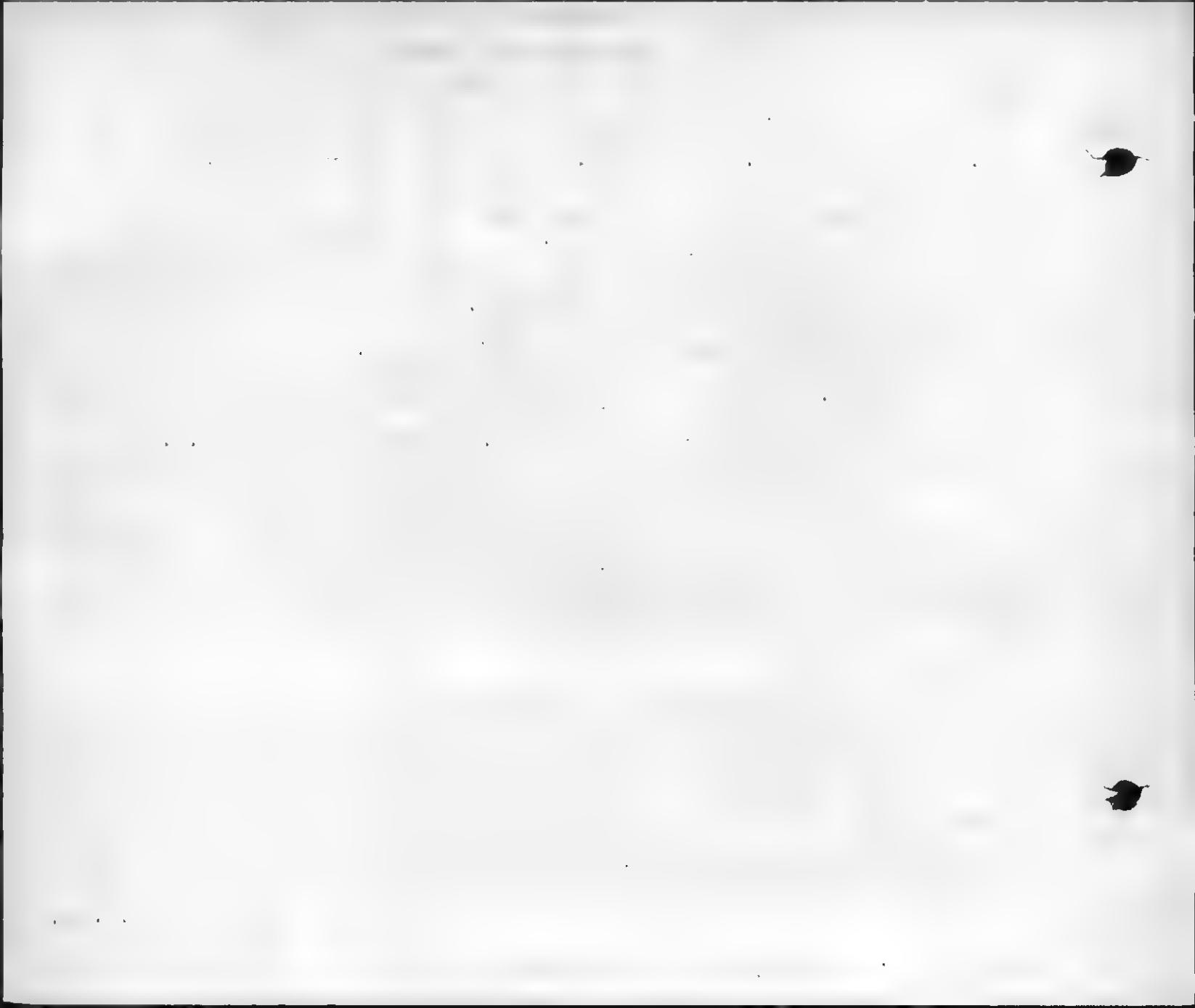
ADDRESS

24a. REC'D BY REGISTRAR

DATE JUN 18 '58

24b. REGISTRAR'S SIGNATURE

Alv. Beach



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please write the word "pending" in pencil in Item 1B. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
730 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07318

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Maryland		c. LENGTH OF STAY IN 1b Life time	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 146 N. Jonathan Street		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Maryland	
3. NAME OF DECEASED (Type or print) Max		First (no)	Middle Kennedy
4. DATE OF DEATH 6 9 19 88		5. SEX Male	6. COLOR OR RACE Colored
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH April 29 1893	9. AGE (In years last birthday) 68 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Restaurants	11. BIRTHPLACE (State or foreign country) Hagerstown, Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Benjamin Kennedy	
14. MOTHER'S MAIDEN NAME Francis Snively		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	
16. SOCIAL SECURITY NO. 217-10-3076		17. INFORMANT Mrs. Clara L. Stewart 337. N Jonathan St	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442.2 DUE TO Conditions, if any, which gave rise to immediate cause (b) due to (c) due to		INTERVAL BETWEEN ONSET AND DEATH 6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coagulation of blood Thrombosis, local, Myocardium 3 years			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Dr. Dev. D. D.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>J. P. F. W. D. T. F. J.</i>		DATE SIGNED <i>6/13/58</i>	
22a. BURIAL CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 6-13-58	22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery
23. FUNERAL DIRECTOR'S SIGNATURE <i>John R. Watson</i>		24a. ADDRESS <i>Hagerstown, Md</i>	24b. REGISTRAR'S SIGNATURE <i>Allie Smith</i>
VS. A15ME SM 2/57		24c. RECORD BY REGISTRAR DATE JUN 13 '58	

last undivided portion will consist of a single
large irregularly rounded hill.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7310

CERTIFICATE OF DEATH

Reg. Dist. No.

07319

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be rejoined by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) b. STATE Maryland		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Md.		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		d. STREET ADDRESS 111 S. Artizan Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Paul	Middle Anderson	Last Leggett	4. DATE OF DEATH	Month June	Day 12	Year 19 58
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Feb. 2 1898	9. AGE (In years lost birthday) 60 yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months 4 Days 9 Hours 0 Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Telegraph Operator		10b. KIND OF BUSINESS OR INDUSTRY Western Md. Railroad		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U. S. A	
13. FATHER'S NAME Howard Leggett		14. MOTHER'S MAIDEN NAME Lucy Anderson					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. No. 705 10 8764		17. INFORMANT Mrs. Mable L. Leggett		Address III S. Artizan St. Williamsport Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 400.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. } (b) DUE TO Coronary Occlusion (c) DUE TO Coronary Drowning						INTERVAL BETWEEN ONSET AND DEATH Decades 4 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 29 Oct 1958 to 12 June 1958, that I last saw the deceased alive on 12 June 1958, and that death occurred at 3:30 P.M. from the causes and on the date stated above						ADDRESS (Street, city or town, state) M.D. 281 W. Patonae Street Williamsport, Md.	
ACTUAL SIGNATURE PAUL HARVEY						DATE SIGNED 12 June 58	
22a. BURIAL CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF June 14-58		22c. NAME OF CEMETERY OR CREMATORIUM Greenlawn Cemetery		22d. LOCATION (City, town, or county) Williamsport Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Doris Leggett Williamsport Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE JUN 16 '58		24b. REGISTRAR'S SIGNATURE Doris Leggett	



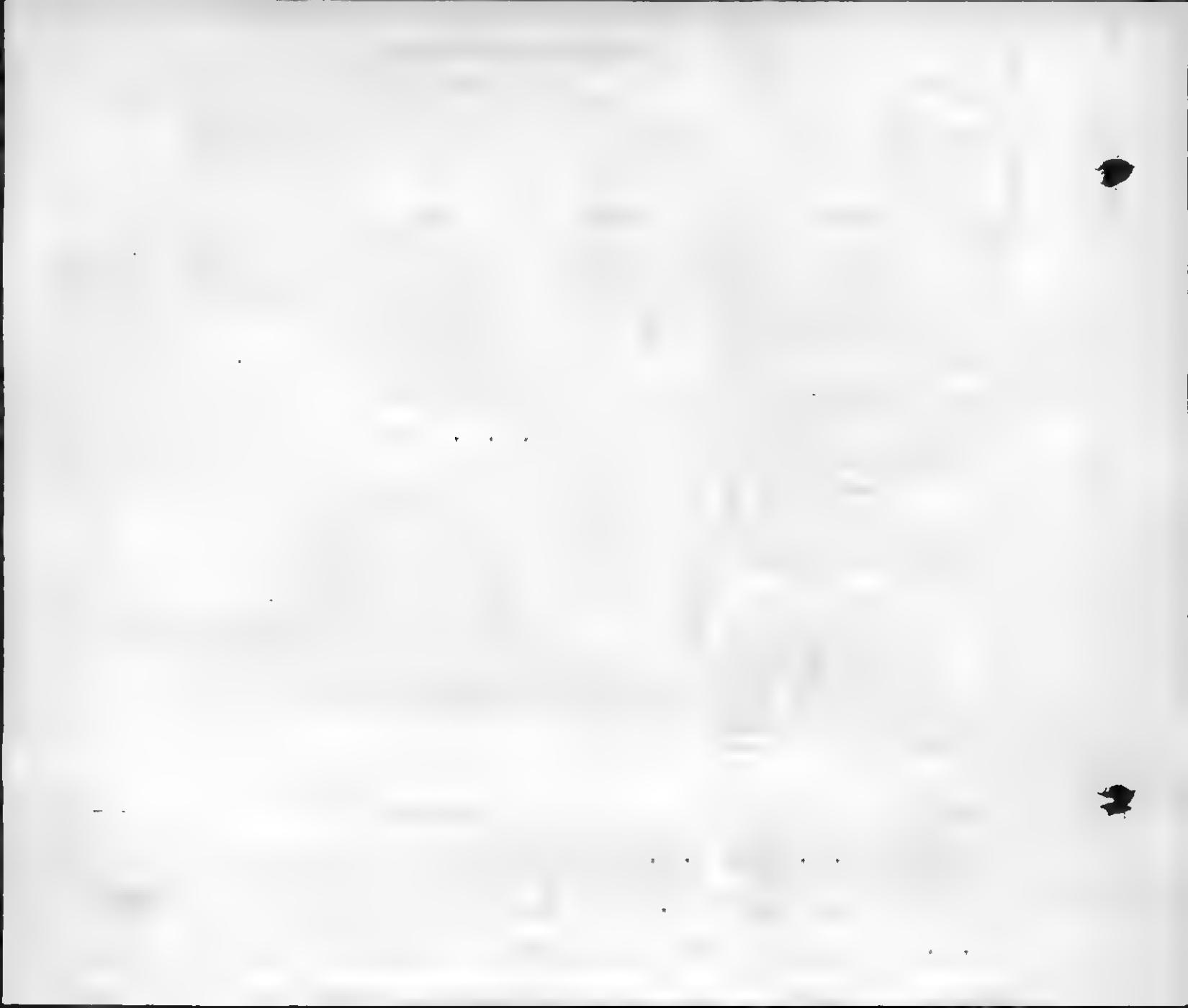
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7353 CERTIFICATE OF DEATH

Reg. Dist. No. 07320

1. PLACE OF DEATH a. COUNTY Washington MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Frederick				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Keedysville			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Point of Rocks				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			d. STREET ADDRESS				
3. NAME OF DECEASED (Type or print)			First DORA	Middle ALICE	Last LILLY		
4. DATE OF DEATH	Month June	Day 2,	Year 1958				
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/>		
Female	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	28 Feb 1864	94 yrs	Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Virginia			
13. FATHER'S NAME Daniel Yowell			14. MOTHER'S MAIDEN NAME Helen Jenkins				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <input type="checkbox"/> No		16. SOCIAL SECURITY NO None		17. INFORMANT Mrs. W. A. Tuck (Same as item #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Generalized arteritis scleroticis</i> DUE TO <i>400.0</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____							
INTERVAL BETWEEN ONSET AND DEATH <i>5 yrs</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>May 26, 1958</i> , to <i>June 2, 1958</i> , that I last saw the deceased alive on <i>June 2, 1958</i> , and that death occurred at <i>410</i> M, from the causes and on the date stated above.						ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <i>E. W. LeVan</i>		M.D.		Boonsboro, Maryland		6-2-58	
PHYSICIAN'S NAME (Type) G. W. LeVan, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) <input type="checkbox"/> Burial		22b. DATE THEREOF June 5, 1958		22c. NAME OF CEMETERY OR CREMATORIUM St. Paul's Cemetery		22d. LOCATION (City, town or county) (State) Point of Rocks, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS		24a. REC'D BY REGISTRAR DATE JUN 4 '58		24b. REGISTRAR'S SIGNATURE <i>Reg. Dist. No. 07320</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

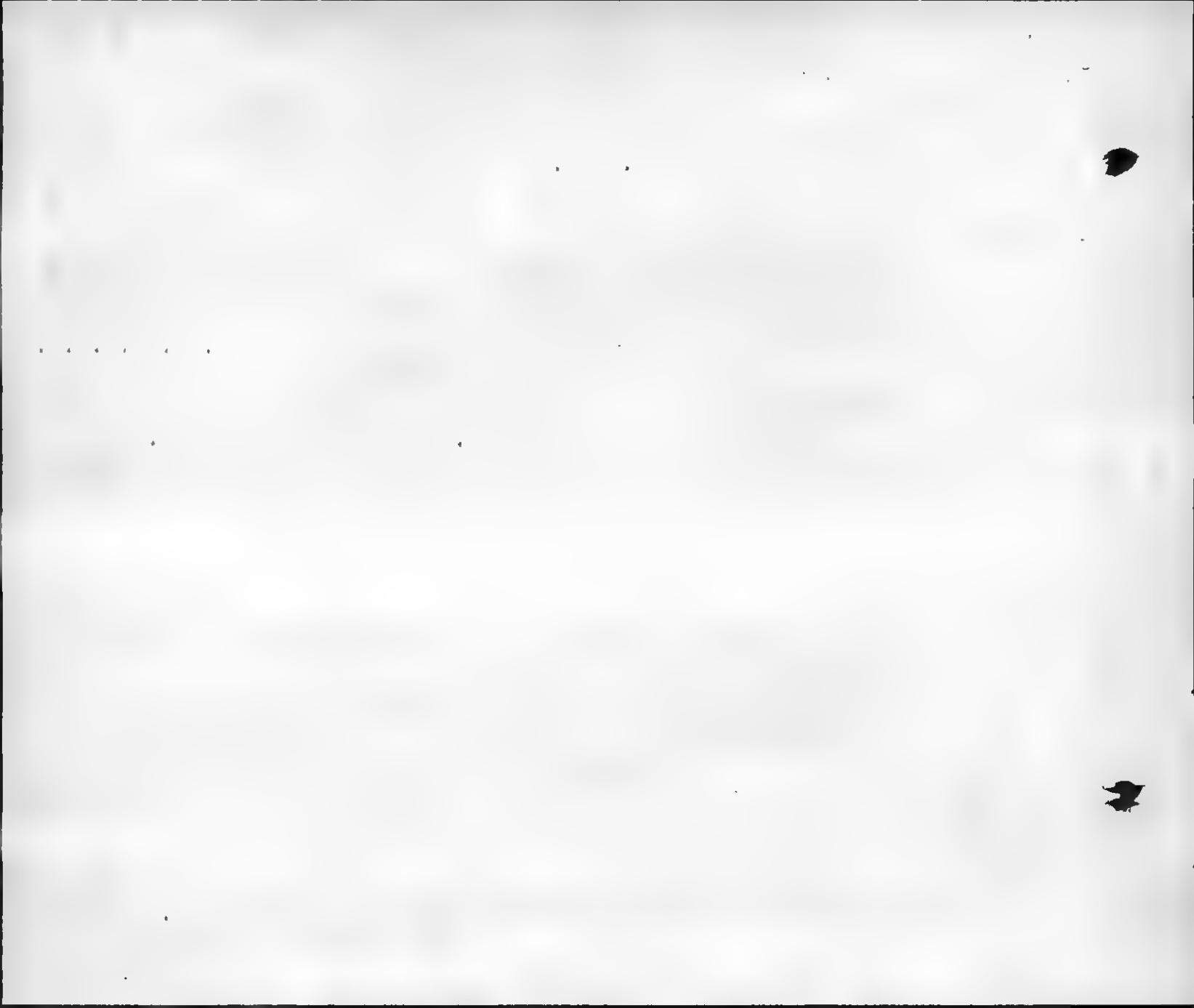
7354

CERTIFICATE OF DEATH

07321

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KEEDYSVILLE		b. COUNTY WASHINGTON	
c. LENGTH OF STAY IN 1b 2 YR. 6 MO.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X KEEDYSVILLE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MAIN STREET		d. STREET ADDRESS MAIN STREET	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First SUSAN	Middle EVELYN	Last LOHMAN
4. DATE OF DEATH	JUNE 10		Month Day Year 19 58
5. SEX	6. COLOR OR RACE FEMALE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 24 1884
9. AGE (In years last birthday) 74 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 MINS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) NEAR KEEDYSVILLE WASH. CO. MD. U.S.A.		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME ABRAM GRIFFITH		14. MOTHER'S MAIDEN NAME NO Record	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Type no or unknown) NO		16. SOCIAL SECURITY NO NONE	
17. INFORMANT LOUIS H. LOHMAN KEEDYSVILLE MD.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X DUE TO <i>Hypertension or cardiovascular disease</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO <i>atherosclerosis</i> (c)		INTERVAL BETWEEN ONSET AND DEATH 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 9, 1958 to June 10, 1958 , that I last saw the deceased alive on June 9, 1958 , and that death occurred at 12:10 AM from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>G.W. LeVan</i>		ADDRESS (Street, city or town, state) Baltimore	
PHYSICIAN'S NAME (Type)		DATE SIGNED 6/11/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JUNE 13 1958	
22c. NAME OF CEMETERY OR CREMATORIUM MOUNTAIN VIEW CEMETERY SHARPSBURG MD.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Cast Jewel Home Boonsboro Md.		24a. REC'D BY REGISTRAR DATE JUN 13 '58	
ADDRESS		24b. REGISTRAR'S SIGNATURE Alv. LeVan	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

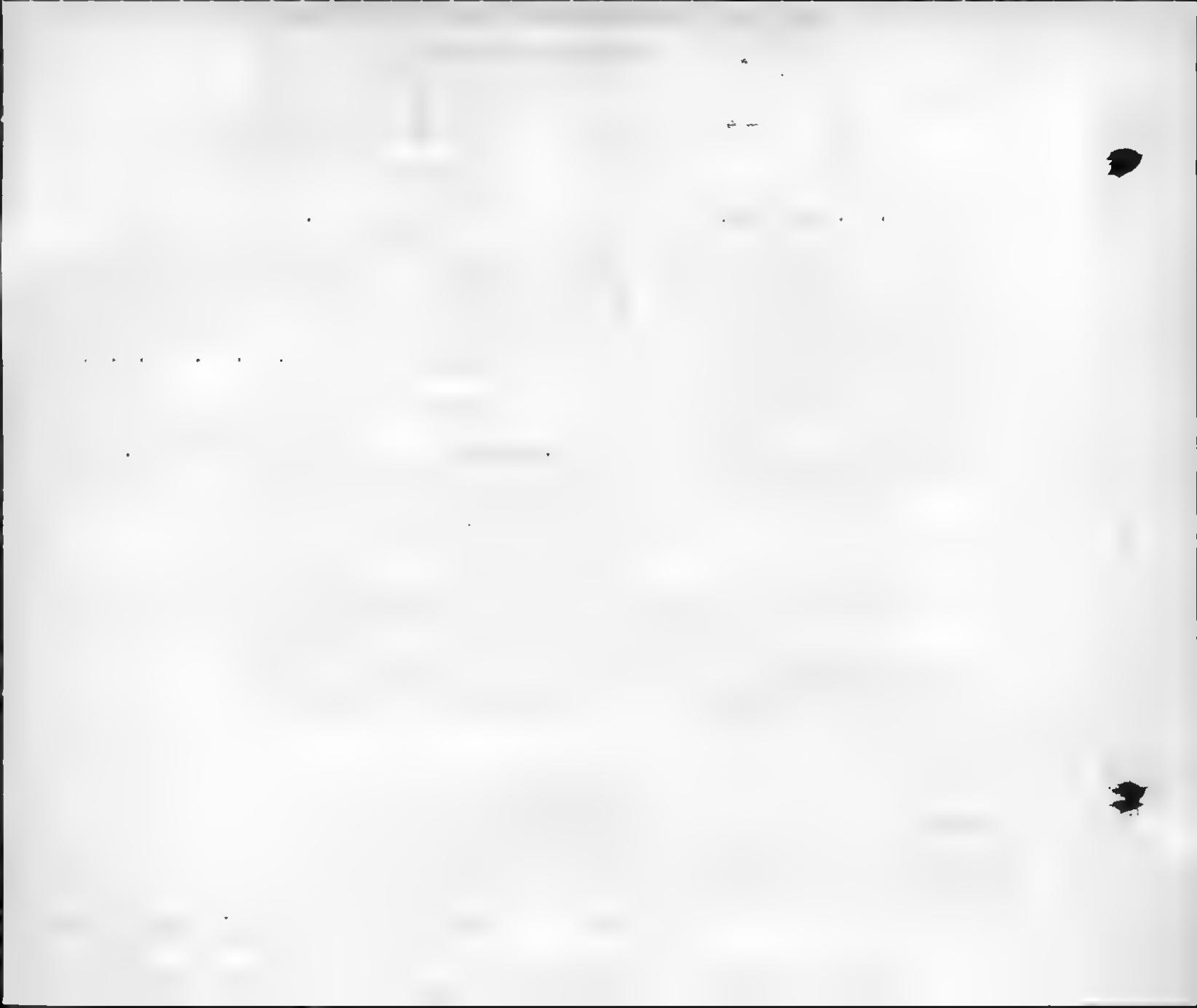
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7311 CERTIFICATE OF DEATH

Reg. Dist. No. **07322**

1. PLACE OF DEATH a. COUNTY WASHINGTON		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b		d. STATE MARYLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASH. CO. HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BAKERSVILLE		b. COUNTY WASHINGTON	
3. NAME OF DECEASED (Type or print) MARY		First BLANCHE	Middle LONG	4. DATE OF DEATH JUNE 16 1958	Month Day Year 19 16 58
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> APRIL 1 1895	9. AGE (In years last birthday) 63 yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min. 12 months 0 days 0 hours 0 min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY OWNHOME		11. BIRTHPLACE (State or foreign country) KEEDYSVILLE WASH. CO. MD. U.S.A.	
13. FATHER'S NAME JOHN HAMMOND		14. MOTHER'S MAIDEN NAME LYDIA BELLE BOWERS		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO. 220-34-2236		17. INFORMANT 937 main ^{Address} avenue HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		DUE TO Hyperthyroidism: a sclerotic heart		INTERVAL BETWEEN ONSET AND DEATH 10 yrs	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		Coronary Thrombosis		5 minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 15, 1958 to June 16, 1958 , that I last saw the deceased alive on June 13, 1958 , and that death occurred at 9:01 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE G. W. Heelan				ADDRESS (Street, city or town, state) 1300 Elwood St. Hagerstown, MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JUNE-19-1958		22c. NAME OF CEMETERY OR CREMATORIUM BAKERSVILLE CEMETERY	
23. FUNERAL DIRECTOR'S SIGNATURE John H. East Bakersville MD		ADDRESS		24a. REC'D BY REGISTRAR DATE JUN 20 '58	
				24b. REGISTRAR'S SIGNATURE John H. East Bakersville MD	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07323

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Washington					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport		c. LENGTH OF STAY IN 1b 2 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Cearfoss							
d. NAME OF HOSPITAL (If not in hospital, give street address) 108 INSTITUTION Williamsport Sanitarium				d. STREET ADDRESS Hagerstown RFD #4		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) NANNIE		First THORA	Middle LONG	4. DATE OF DEATH	Month June	Day 22,	Year 19 58				
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> X	8. DATE OF BIRTH Jan. 6, 1875	9. AGE (in years last birthday) 83 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days Hours Min				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Downsville Dist Wash Co		12. CITIZEN OF WHAT COUNTRY Ind. USA					
13. FATHER'S NAME Joseph R. Long		14. MOTHER'S MAIDEN NAME Elizabeth Lesher		Address							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Name, no. or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Kenneth Long, Hagerstown R 16		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Carpal Nervous Disease (c) DUE TO 5 yrs					
19. MEDICAL CERTIFICATION		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. (City or town) (County) (State)		20f. (City or town) (County) (State)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
21. I certify that I attended the deceased from 2-1-1958 to 6-22-1958, that I last saw the deceased alive on 6-19-58, and that death occurred at Hagerstown, Md. M. from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED		22. BUR. AL. CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/26/58		22c. NAME OF CEMETERY OR CEMETORY Elanor Cemetery		22d. LOCATION (City, town, or county) nr. Tilquanton-Wash. Co.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman-Hagerstown, Maryland		ADDRESS		24a. REC'D BY REGISTRAR DATE JUN 26 '58		24b. REGISTRAR'S SIGNATURE Alt. esch					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7312 CERTIFICATE OF DEATH

07324

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Washington		2 USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 50 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 445 Salem Ave.		e. STREET ADDRESS 445 Salem Ave.	
3 NAME OF DECEASED (Type or print) SALLY DRURY LUCKMAN		4. DATE OF DEATH June 6, 1958	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 4, 1874
9. AGE (In years last birthday) 83 yrs	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Penns. Mercersberg-Franklin Co. USA
12. CITIZEN OF WHAT COUNTRY No. USA	13. FATHER'S NAME Cyrus Shipp		
14. MOTHER'S MAIDEN NAME Mary Eckard		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No	
16. SOCIAL SECURITY NO. 817-32-5691		17. INFORMANT Edward Luckman-445 Salem Ave.-Hagers.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>420.5</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>arterial sclerosis that caused</i> (c) <i>5 yrs</i>			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) Hagers.		(County) (State)	
21. I certify that I attended the deceased from <i>3-1-1958</i> to <i>6-6-1958</i> that I last saw the deceased alive on <i>5-20-58</i> , and that death occurred at <i>Hagers.</i> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Dr. Ed. Dith</i>		ADDRESS (Street, city or town, state) <i>Hagers.</i>	
PHYSICIAN'S NAME (Type) <i>Dr. Edward Dith</i>		DATE SIGNED <i>6/6/58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-8-58	22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery	22d. LOCATION (City, town, or county) Hagers., Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman-Hagerstown, Maryland	ADDRESS	24a. REC'D BY REGISTRAR DATE JUN 10 '58	24b. REGISTRAR'S SIGNATURE <i>Al. L. Smith</i>

1. *Leucostoma* *luteum* (L.) Pers.
2. *Leucostoma* *luteum* (L.) Pers.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07325

7313

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
d. COUNTY

Washington

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Hagerstown, Maryland

c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

Washington County Hospital

3. NAME OF
DECEASED
(Type or print)First
MaryMiddle
ElizabethLast
Mamel

5. SEX

6. COLOR OR RACE

Female Colored

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

March 2 1883

9. AGE (In years
last birthday) 76 yrs

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Domestic

13. FATHER'S NAME

Isaiah Wheeler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown)

no

(If yes, give war or dates of service)

none

16. SOCIAL SECURITY NO.

17. INFORMANT

Alice Mamel 426 Sumans Ave.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which

gave rise to immediate

cause (a), stating the under-

lying cause lost.

(b)

DUE TO

(c)

DUE TO

INTERVAL BETWEEN
ONSET AND DEATH19. WAS AUTOPSY
PERFORMED?YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)

20c. TIME OF INJURY Month, Day, Year

Hour o. m.

p. m.

19

While of work at work

20d. INJURY OCCURRED

While of work at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from

alive on

Dec 26, 1958, to

Dec 27, 1958, that I last saw the deceased

alive on

Dec 27, 1958, and that death occurred at 11:30 A.M.

from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE

Philip J. Hirshman, M.D.

PHYSICIAN'S
NAME (Type)22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

6-11-1958

22c. NAME OF CEMETERY OR CREMATORI

Rose Hill Cemetery

22d. LOCATION (City, town, or county)

(State)

Hagerstown Maryland

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

John R. Watson, Hagerstown, Md.

24a. REC'D BY REGISTRAR

DATE JUN 12 '58

24b. REGISTRAR'S SIGNATURE

Abelsoeuch

TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 1

to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director.

Page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in apparent within 72 hours after death.

VS A15 (4)

15M 9/55

Wir schenken Ihnen ein

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Entered 7-21-58 7-21-58

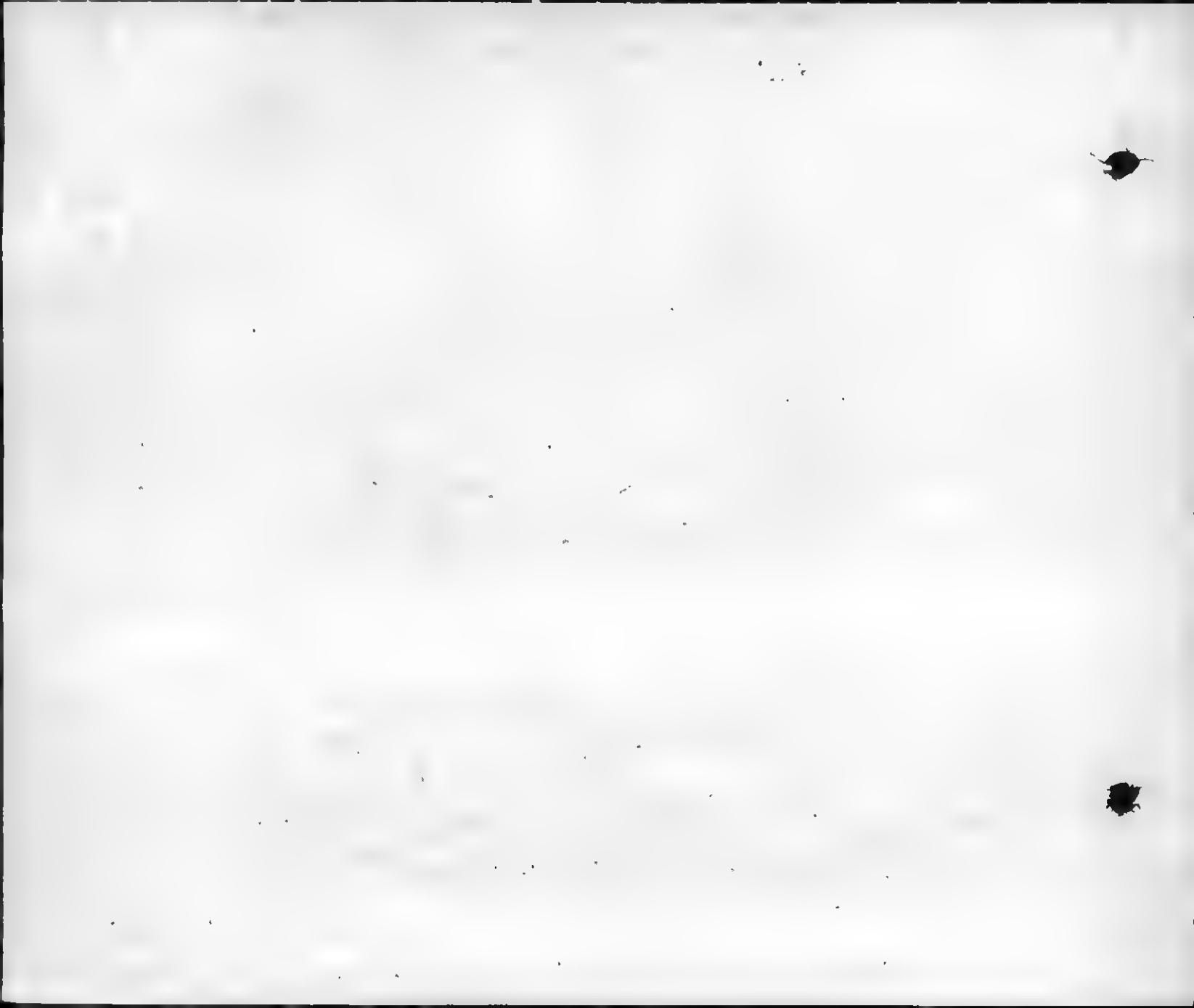
7356

CERTIFICATE OF DEATH

07326

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown R # 2		c. LENGTH OF STAY IN 1b 5Yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown R # 2		d. STREET ADDRESS "Willsons			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION "Willsons				d. STREET ADDRESS "Willsons		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) HARVEY		First JACOB	Middle MARTIN	Lost MARTIN	4. DATE OF DEATH June 28 1958	Month June	Day 28	Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 17, 1872		9. AGE (in years last birthday) 85 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. Hours	13. Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clergyman		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Greencastle Franklin Co USA		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Samuel H. Martin		14 MOTHER'S MAIDEN NAME Catherine Shank							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT S. Dorsey Martin Hagerstown Md. R # 2		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.0		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		"Willsons Clergyman, Admitted Heart Disease 10 yrs Cerebrovascular Disease 4 yrs		INTERVAL BETWEEN ONSET AND DEATH			
DUE TO (c)									
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Hagerstown		(County) Md.	
21. I certify that I attended the deceased from 3-1-58 19 to 6-20-1958 that I last saw the deceased alive on 6-23-58 19, and that death occurred at 3 M, from the causes and on the date stated above.				ADDRESS (Street, City or town, state)		DATE SIGNED 9-20-58			
ACTUAL SIGNATURE Dr. E. W. Coffman		M.D.							
PHYSICIAN'S NAME (Type) TREW W. Coffman									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/30/58		22c. NAME OF CEMETERY OR CREMATORIUM Dunkard Cemetery		22d. LOCATION (City, town, or county) Brookfording sh. Co. Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE JUL 2 1958		24b. REGISTRAR'S SIGNATURE Coffman			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07327

7357

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director,
 page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLEAR SPRING</u>		c. LENGTH OF STAY IN 1b <u>LIFE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MAIN STREET</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLEAR SPRING</u>	
3. NAME OF DECEASED (Type or print) <u>JAMES R. BREWER</u>		First <u>JAMES</u>	Middle <u>ALFRED</u>
4. DATE OF DEATH <u>JUN 19 1958</u>		5. SEX <u>M</u>	6. COLOR OR RACE <u>WHITE</u>
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/15/1878</u>	
9. AGE (in years lost birthday) yrs. <u>83</u>		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	
11. IF UNDER 24 HRS Hours <u>0</u> Min <u>0</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES CREE</u>		14. MOTHER'S MAIDEN NAME <u>CATHERINE MILLS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>215-26-770</u>	
17. INFORMANT <u>S. R. AND A. Y.</u>		Address <u>101 W. 10th Street, Baltimore, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CHRONIC CARDIAC FAILURE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO CURE. BRONCHIECTASIS (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3 days.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Clear Spring</u>		20f. (City or town) <u>WASHINGTON</u> (County) <u>DC</u> (State) <u>MD</u>	
21. I certify that I attended the deceased from <u>June 17, 1958</u> to <u>June 20, 1958</u> , that I last saw the deceased alive on <u>June 19, 1958</u> , and that death occurred at <u>10:45 A.M.</u> from the causes and on the date stated above ACTUAL SIGNATURE <u>David R. Brewer</u> M.D. ADDRESS (Street, city or town, state) PHYSICIAN'S NAME (Type) <u>David R. Brewer</u> DATE SIGNED <u>6/23/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		22b. DATE THEREOF <u>6/23/58</u>	
22c. NAME OF CEMETERY OR CREMATORIAL <u>ST. MARY'S</u>		22d. LOCATION (City, town, or county) <u>WASHINGTON, D.C.</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Clark</u>		ADDRESS <u>CLEAR SPRING, MD.</u>	
24a. REC'D BY REGISTRAR <u>MUN 24 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Alfred Clark</u>	

TO **DEPUTY MEDICAL EXAMINER:** This certificate should be executed in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
X
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07328

Reg. Dist. No.

7314

1. PLACE OF DEATH
a. COUNTY

Washington

MARYLAND

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)

a. STATE Virginia

b. COUNTY Wise

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Hagerstown

c. LENGTH OF STAY IN 1b

9 weeks

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Norton

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

e. IS RESIDENCE
ON A FARM?
YES NO

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month

Day

Year
1958

Anna

Laura

Meador

5. SEX
female

6. COLOR OR RACE
white

7. MARRIED NEVER MARRIED 8. DATE OF BIRTH

Sept. 6, 1895

9. AGE (In years
at birthday)
63 yrs.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

house wife

10b. KIND OF BUSINESS OR INDUSTRY

own home

11. BIRTHPLACE (State or foreign country)

Norton, Virginia

13. FATHER'S NAME

John Whitaker

14. MOTHER'S MAIDEN NAME

Carmellia Chapman

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

no

16. SOCIAL SECURITY NO.

(If yes, give war or dates of service)

17. INFORMANT

Mrs. Eleanor Burgess, Norton, Va.

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY;
IMMEDIATE CAUSE (a)

445X

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(b)

DUE TO

(c)

Hypertension *Cocler Vascular Disease* *2 yrs*

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

19. WAS AUTOPSY
PERFORMED?
YES NO

20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m.

20d. INJURY OCCURRED
While at work Not while at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

ACTUAL
SIGNATURE

John E. S. S. S.

M.D. CHIEF MEDICAL EXAMINER

DATE SIGNED
6/30/58

EXAMINER'S
NAME (Type)

Dr. E. S. S. S.

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

22a. BURIAL, CREMATION, 22b. DATE THEREOF
REMOVAL (Specify)

burial

6-10-58

22c. NAME OF CEMETERY OR CREMATORIUM

Highland Cemetery

22d. LOCATION (City, town, or county)

Norton, Virginia

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

Scott F. Minnich & Son, Hagerstown, Md.

ADDRESS

24a. REC'D BY REGISTRAR

JUN 13 '58

24b. REGISTRAR'S SIGNATURE

Alb. esuch



67329

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

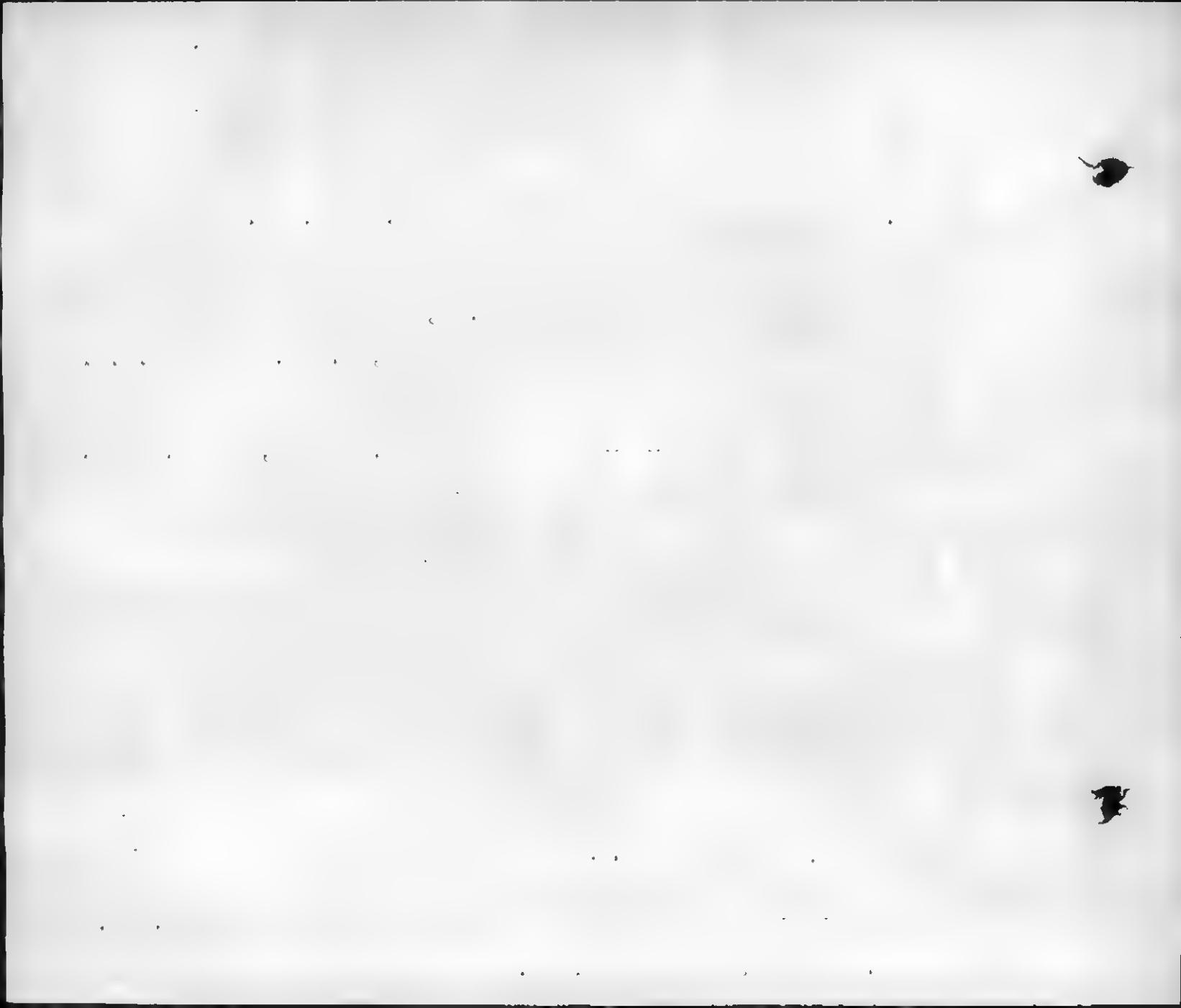
Dr. Wells

Reg. Dist. No. 302

FOR STATE
HEALTH DEPT.

TO FUNERAL DIRECTOR: This certificate should be executed by the certifying physician, writing the word "pending" in pencil in item 1B. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission)	
<p>a. COUNTY Washington</p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown</p> <p>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Wash. County Hospital</p>		<p>a. STATE Maryland</p> <p>b. COUNTY Washington</p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown</p> <p>d. STREET ADDRESS 156 W. Wash. St.</p>	
<p>3. NAME OF DECEASED (Type or print) Ira</p> <p>5. SEX Female</p> <p>6. COLOR OR RACE White</p> <p>7. MARRIED WIDOWED</p>		<p>First Ethel</p> <p>Middle Miller</p> <p>8. DATE OF BIRTH Mar. 3, 1921</p> <p>9. AGE (In years last birthday) 37 yrs</p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife</p> <p>13. FATHER'S NAME Ira Henson</p>		<p>10b. KIND OF BUSINESS OR INDUSTRY Own Home</p> <p>11. BIRTHPLACE (State or foreign country) Thomas, W. Va.</p> <p>14. MOTHER'S MAIDEN NAME Martha Brown</p>	
<p>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Tot. no. or unknown) no</p>		<p>16. SOCIAL SECURITY NO. 232-26-4778</p> <p>17. INFORMANT George E. Miller, 156 W. Wash. St.</p>	
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last.</p>		<p>Multiple Fractured ribs; Fractured body of the 7th and 8th thoracic vertebrae; Lacerations of lungs, spleen & 1st kidney; bi-lateral colles' fracture (Closed); Hemorrhage and shock; Acute Pericarditis</p>	
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) None</p>		<p>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>	
<p>20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</p>		<p>20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Patient fell from 3rd floor apartment to ground</p>	
<p>20c. TIME OF INJURY Hour XXX. 4:00 p.m.</p>		<p>20d. INJURY OCCURRED While <input type="checkbox"/> of work <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work</p>	
<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home</p>		<p>20f. (City or town) Hagerstown</p>	
<p>(County) Wash</p>		<p>(State) Md</p>	
<p>21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></p>			
<p>ACTUAL SIGNATURE <i>S. Robert Wells, M.D.</i></p>		<p>DATE SIGNED 6-21-58</p>	
<p>EXAMINER'S NAME (Type) S. Robert Wells, M.D.</p>		<p>CHIEF MEDICAL EXAMINER <input type="checkbox"/></p>	
		<p>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/></p>	
		<p>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/></p>	
<p>22e. BURIAL, CREMATON, REMOVAL (Specify) Burial</p>		<p>22f. DATE THEREOF 6-23-1958</p>	
<p>23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman, Hagerstown, Md.</p>		<p>22g. NAME OF CEMETERY OR CREMATORIAL ADDRESS Evangelical Church Cemetery, Sleepy Creek, W. Va.</p>	
		<p>24e. REC'D BY REGISTRAR JUN 23 1958</p>	
		<p>24f. REGISTRAR'S SIGNATURE <i>Robert Wells</i></p>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7358

CERTIFICATE OF DEATH

Reg. Dist. No.

07330

1. PLACE OF DEATH a. COUNTY WASHINGTON		2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town BOONSBORO		b. COUNTY WASHINGTON	
c. LENGTH OF STAY IN 1b 16 MONTHS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BOONSBORO	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION REEDER NURSING HOME		d. STREET ADDRESS NUMBER 65 SOUTH MAIN ST.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First ESTA	Middle M	Last MOSER
4. DATE OF DEATH JUNE 26 1958	Month 19	Day 19	Year
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JANUARY 14 1873
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) NEAR MIDDLETOWN FRED. CO. MD. U.S.A.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME WILLIAM BOWLUS		14. MOTHER'S MAIDEN NAME MARY SHEFFER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT RALPH T. MOSER BOONSBORO MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443 X DUE TO <i>Hypertension with cerebral hemorrhage</i> Heart INTERVAL BETWEEN ONSET AND DEATH 5 years			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 23</u> , 1958, to <u>June 25</u> , 1958, that I last saw the deceased alive on <u>June 25</u> , 1958, and that death occurred at <u>6 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <u>John W. Ball Sr.</u> M.D. <u>Boonsboro</u> DATE SIGNED <u>6/27/58</u>			
22a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JUNE 28 1958	
22c. NAME OF CEMETERY OR CREMATORIAL UNITED BRETHREN CEMETERY MYERSVILLE FRED. CO. MD.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John W. Ball Sr. - Boonsboro MD.</u>		24a. REC'D BY REGISTRAR DATE JUL 1 '58	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>John W. Ball Sr.</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07331

7359

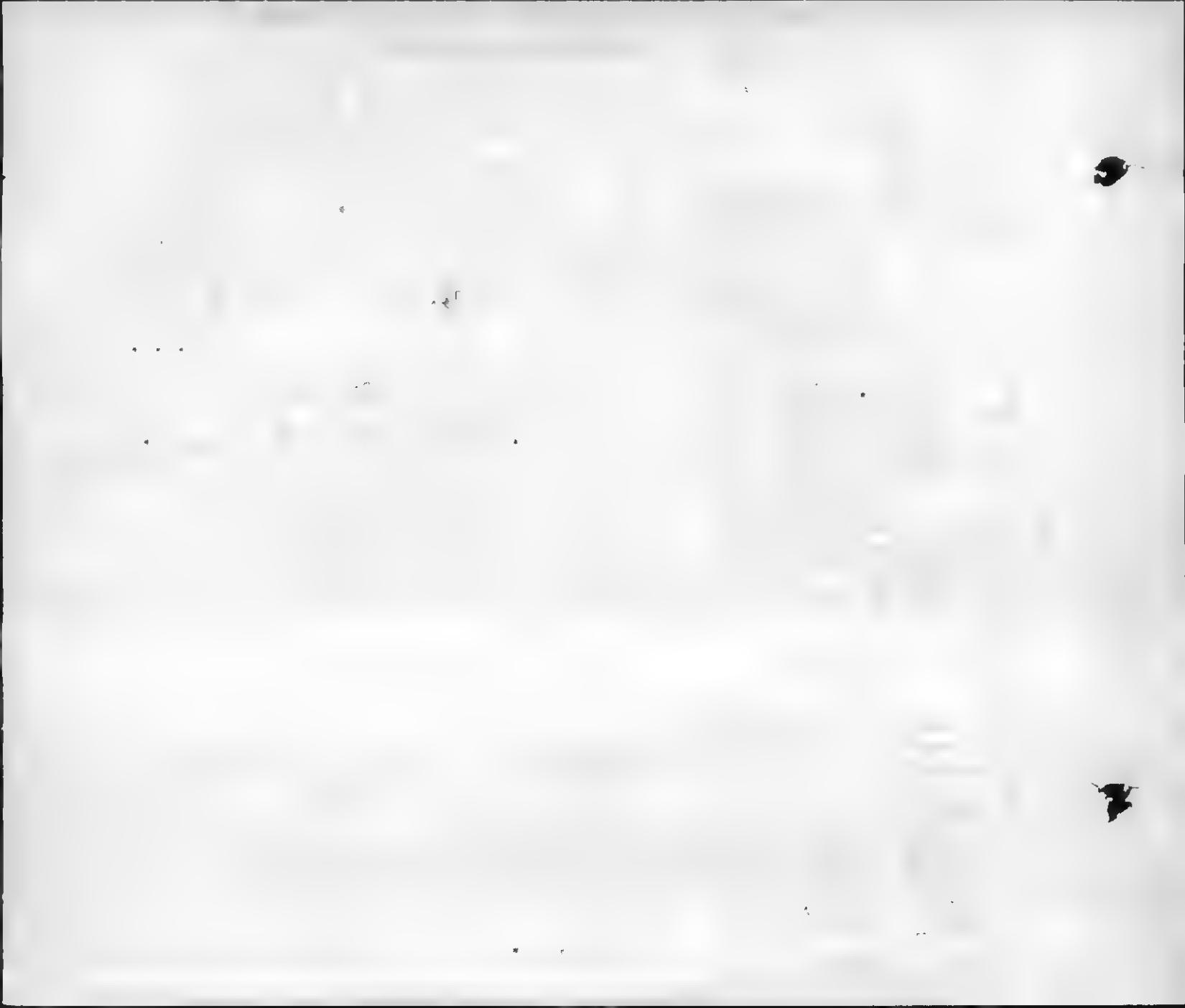
CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Gateway Convalescent Home		d. STREET ADDRESS 55 Wayside Ave.	
e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First ELLA	Middle MAY	Last NAILL
4. DATE OF DEATH	Month June	Day 14	Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 12, 1879
9. AGE (In years lost birthday) 78 yrs	10. IF UNDER 1 YEAR Months 10	11. IF UNDER 24 HRS Days 2	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John E. Naill		14. MOTHER'S MAIDEN NAME Eliza Plaine	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO none	
17. INFORMANT Mrs. Eleanor Caldwell Leesburg, Va.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 150X		INTERVAL BETWEEN ONSET AND DEATH 3 weeks	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Cerebral Hemorrhage (c)		Carcinoma of Esophagus 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour e. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 4, 1957</u> to <u>June 14, 1958</u> that I last saw the deceased alive on <u>June 14, 1958</u> , and that death occurred at <u>7:55 AM</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>David R. Brewer</u> M.D. ADDRESS (Street, city, or town, state) PHYSICIAN'S NAME (Type) <u>David R. Brewer, M.D.</u> DATE SIGNED <u>6/16/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/17, 1958	
22c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery		22d. LOCATION (City, town, or county) Hagerstown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Suter-Youzer Funeral Home R. Franklin Page		24a. ADDRESS Hagerstown, Md.	
		24b. REC'D BY REGISTRAR DATE JUN 20 '58	
		24c. REGISTRAR'S SIGNATURE <u>John L. French</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07332

7316

CERTIFICATE OF DEATH

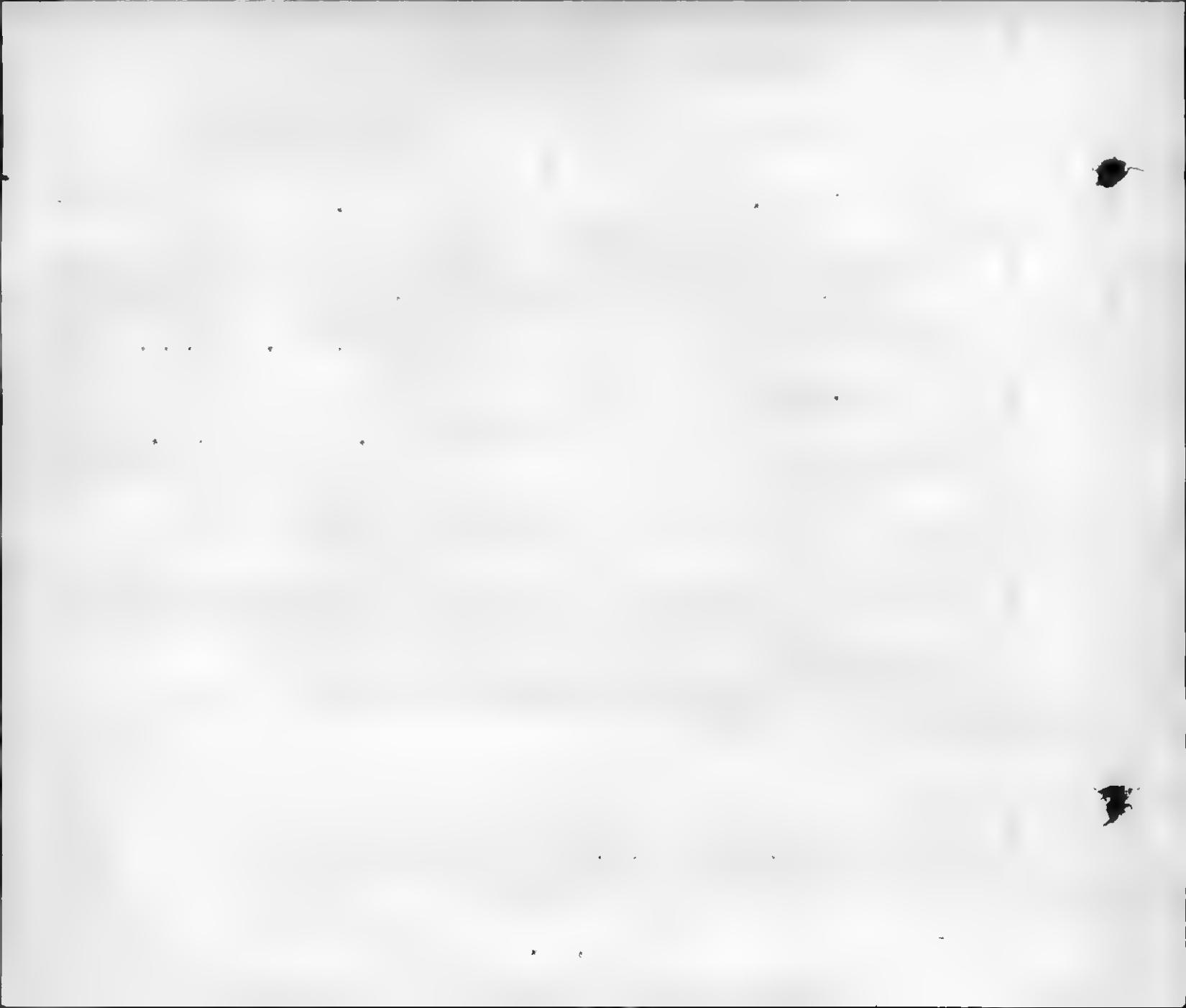
Reg. Dist. No.

302

1. PLACE OF DEATH o COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 70 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 835 Oak Hill Ave.		d. STREET ADDRESS 835 Oak Hill Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First MARY	Middle SHADE	Last OSWALD
4. DATE OF DEATH	Month June	Day 6	Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 22, 1871
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Mc Connellsburg, Penn.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Nevin B. Shade		14. MOTHER'S MAIDEN NAME Flora La Trippe	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO none	
17. INFORMANT Edward Oswald, Jr. Hagerstown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause, if any: DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Arteriosclerotic heart disease, 1 month	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cerebral arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6 Glebe, 1958</u> , to <u>1958</u> , that I last saw the deceased alive on <u>6/25/58</u> , and that death occurred at <u>1516 M</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>Richard T. Binford</u> PHYSICIAN'S NAME (Type) <u>RICHARD T. BINFORD, M. D.</u>		ADDRESS (Street, city or town, state) 1135 POTOMAC AVENUE DATE SIGNED 7 JUNE 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/8/1958	
22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery		22d. LOCATION (City, town, or county) Hagerstown Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Suter-Rouzer Funeral Home R. Franklin Rouzer		24a. REC'D BY REGISTRAR DATE JUN 11 '58	
ADDRESS Hagerstown, Md.		24b. REGISTRAR'S SIGNATURE Alfred E. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 7360 CERTIFICATE OF DEATH

07333

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PONDSVILLE RURAL		b. COUNTY WASHINGTON	
c. LENGTH OF STAY IN 1b 2 YEARS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PONDSVILLE RURAL	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SMITHSBURG MD. ROUTE 2		d. STREET ADDRESS SMITHSBURG MD. ROUTE 2	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) HARRY	First	Middle	Last
4. DATE OF DEATH JUNE 16 1958	Month	Day	Year 19
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOVEMBER 3 1885
9. AGE (In years last birthday) 72 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. Hours
13. FATHER'S NAME WILLIAM PALMER	14. MOTHER'S MAIDEN NAME EDITH NALLEY	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. 17. INFORMANT MRS. MAUDE A. PALMER SMITHSBURG MD. R. 1.	Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] Part I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (b) - - - - X DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the under- lying cause (a). (b) DUE TO (c) Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
INTERVAL BETWEEN ONSET AND DEATH 6 mo.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 7/1/58
20f. (City or town) Hagerstown	(County)	(State)	
21. I certify that I attended the deceased from <u>7/1/58</u> , 1958, to <u>6/16/58</u> , 1958, that I last saw the deceased alive on <u>6/13/58</u> , 1958, and that death occurred at <u>3:10 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE Dr. D. J. Boyer PHYSICIAN'S NAME (Type)			
DATE SIGNED 6/17/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF JUNE 18 1958	22c. NAME OF CEMETERY OR CREMATORIUM ROSE HILL CEMETERY	22d. LOCATION (City, town, or county) HAGERSTOWN WASH. CO. MD.
23. FUNERAL DIRECTOR'S SIGNATURE John H. Baet	ADDRESS Boonsboro Rd.	24a. REC'D BY REGISTRAR DATE JUN 20 '58	24b. REGISTRAR'S SIGNATURE One Baet

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

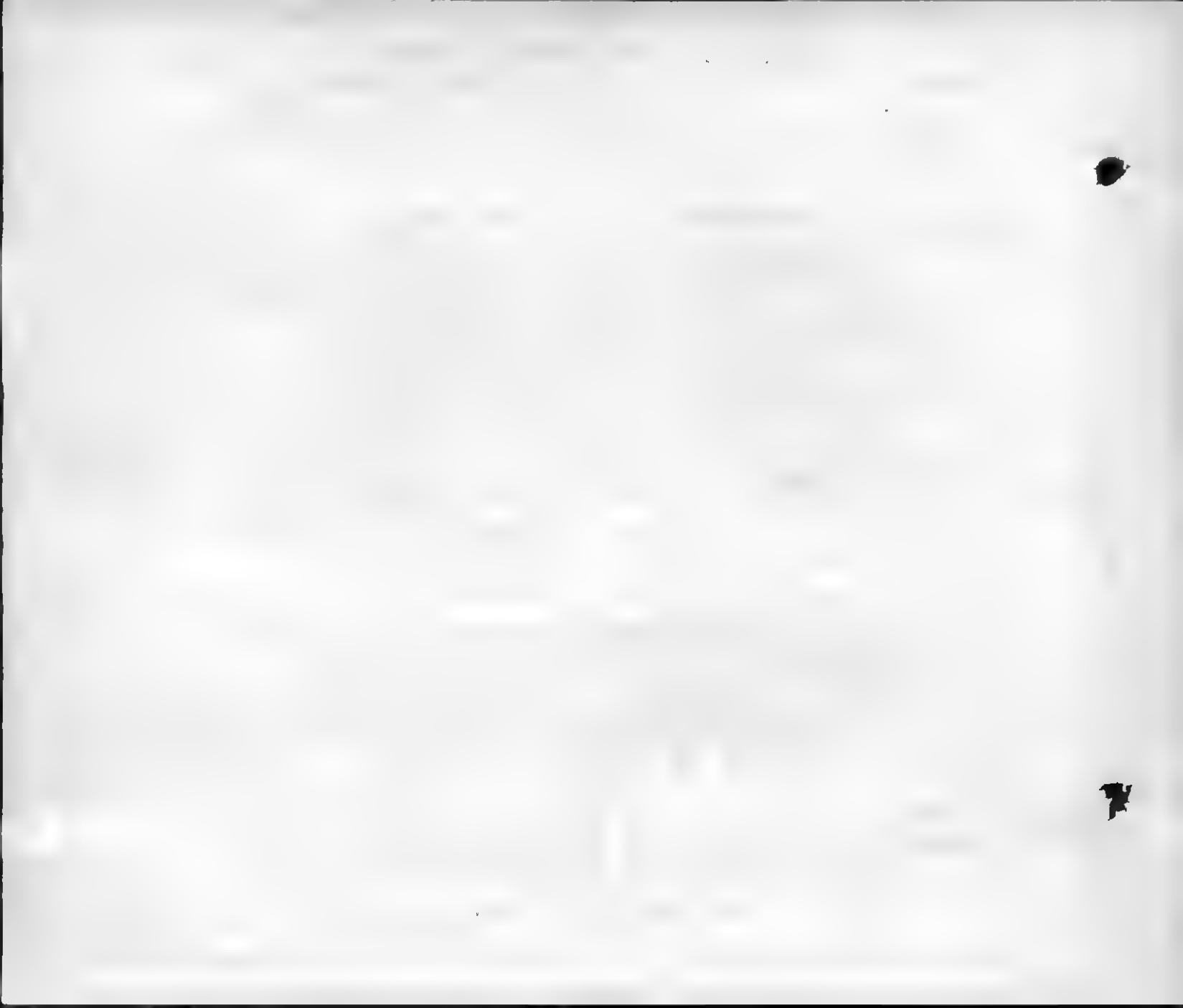
07334

7317

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN lb 14 DAYS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WESTERN MARYLAND STATE HOSPITAL		d. STREET ADDRESS 234 S. CALHOUN ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First GEORGE	Middle	Lost PAPPAS	4. DATE OF DEATH JUNE 4 1958	Month JUNE	Day 4	Year 1958
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 19, 1884	9. AGE (In years last birthday) 74 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RESTAURANT KEEPER		10b. KIND OF BUSINESS OR INDUSTRY RESTAURANT		11. BIRTHPLACE (State or foreign country) GREECE		12. CITIZEN OF WHAT COUNTRY? GREECE.	
13. FATHER'S NAME CHRIS PAPPAS		14. MOTHER'S MAIDEN NAME DIANE					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no unknown) NO		16. SOCIAL SECURITY NO		17. INFORMANT WIFE JENNIE PAPPAS		Address 234 S. CALHOUN ST. BALTIMORE, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c) DUE TO		BRONCHO PNEUMONIA		INTERVAL BETWEEN ONSET AND DEATH 7 DAYS.			
CEREBRAL VASCULAR ACCIDENTS.				1 YEAR.			
ESSENTIAL HYPERTENSION.				7 YEARS.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		GENERALISED ARTERIOSCLEROSIS, CHRONIC UREMIA.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from MAY 21, 1958 to JUNE 4, 1958 , that I last saw the deceased alive on JUNE 4, 1958 , and that death occurred at 4:10 P.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state) 1500 PENNSYLVANIA AVE, 6/4/58		DATE SIGNED 6/4/58	
ACTUAL George Bercu.		M.D.					
PHYSICIAN'S NAME (Type) DR. G. BERCU.				HAGERSTOWN, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-7-58		22c. NAME OF CEMETERY OR CREMATORIUM Greek Orthodox Cem.		22d. LOCATION (City, town, or county) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE One J. Dickner & Sons Baltimore MD.		ADDRESS 1500 Pennsylvania Ave, Baltimore MD.		24a. REC'D BY REGISTRAR JUN 5 '58		24b. REGISTRAR'S SIGNATURE Dee Smith	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07335

7318

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE Md. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 42 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 108 E. Washington St.,		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
3. NAME OF DECEASED (Type or print) Charles S. Paynter		d. STREET ADDRESS 108 E. Washington St.,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 6, 1879
9. AGE (In years lost birthday) 78 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY City of Hagerstown	11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY U.S.A.			
13. FATHER'S NAME James William Paynter		14. MOTHER'S MAIDEN NAME Mary Catherine Roderick	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-09-2133 17. INFORMANT Mrs. Roger E. Haynes Address Hagerstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary insufficiency 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1½ hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b) Arteriosclerosis, generalized		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 4, 1958, to June 4, 1958, that I last saw the deceased alive on June 4, 1958, and that death occurred at 2:45 P.M., from the causes and on the date stated above D.S.T. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <i>W. T. Layman, M.D.</i> M.D. 100 Professional Arts Bldg 6/6/58			
PHYSICIAN'S NAME (Type) William T. Layman, M.D.		Hagerstown Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 6-7-58	22c. NAME OF CEMETERY OR CREMATORIUM Rest Haven Cemetery
22d. LOCATION (City, town, or county) Hagerstown		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss Hagerstown, Md.		24a. REC'D BY REGISTRAR JUN 9 58 DATE	
24b. REGISTRAR'S SIGNATURE <i>John L. Smith</i>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7319

CERTIFICATE OF DEATH

07336

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 30 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 946 Mulberry Ave.		d. STREET ADDRESS 946 Mulberry Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First HAZEL	Middle MILDRED	Last PHILLIPS
4. DATE OF DEATH June	Month 21	Day 1958	Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH December 25, 1890
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months 5	11. IF UNDER 24 HRS Days 26
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Hughesville, Penn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Grant Berrey		14. MOTHER'S MAIDEN NAME Sarah Ann Stugard	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO none	
17. INFORMANT Eugene J. Phillips		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. INTERVAL BETWEEN ONSET AND DEATH 10 yrs +	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 1946, 19, to 21 June, 1958, that I last saw the deceased alive on 21 Jun 58, 19, and that death occurred at 3 A.M., from the causes and on the date stated above. ACTUAL SIGNATURE F. F. Lusby M.D. 230 W Potomac St PHYSICIAN'S NAME (Type) F. F. Lusby ADDRESS (Street, city or town, state) Hagerstown, Md. DATE SIGNED 21 Jun 58			
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/23/1958	
22c. NAME OF CEMETERY OR CREMATORIAL Rest Haven Cemetery		22d. LOCATION (City, town, or county) Hagerstown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Suter-Houser Funeral Home R. Frank Suter, Owner		24a. ADDRESS Hagerstown, Md.	
24b. REC'D BY REGISTRAR JUN 23 '58		24c. REGISTRAR'S SIGNATURE John Suter	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-troune permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

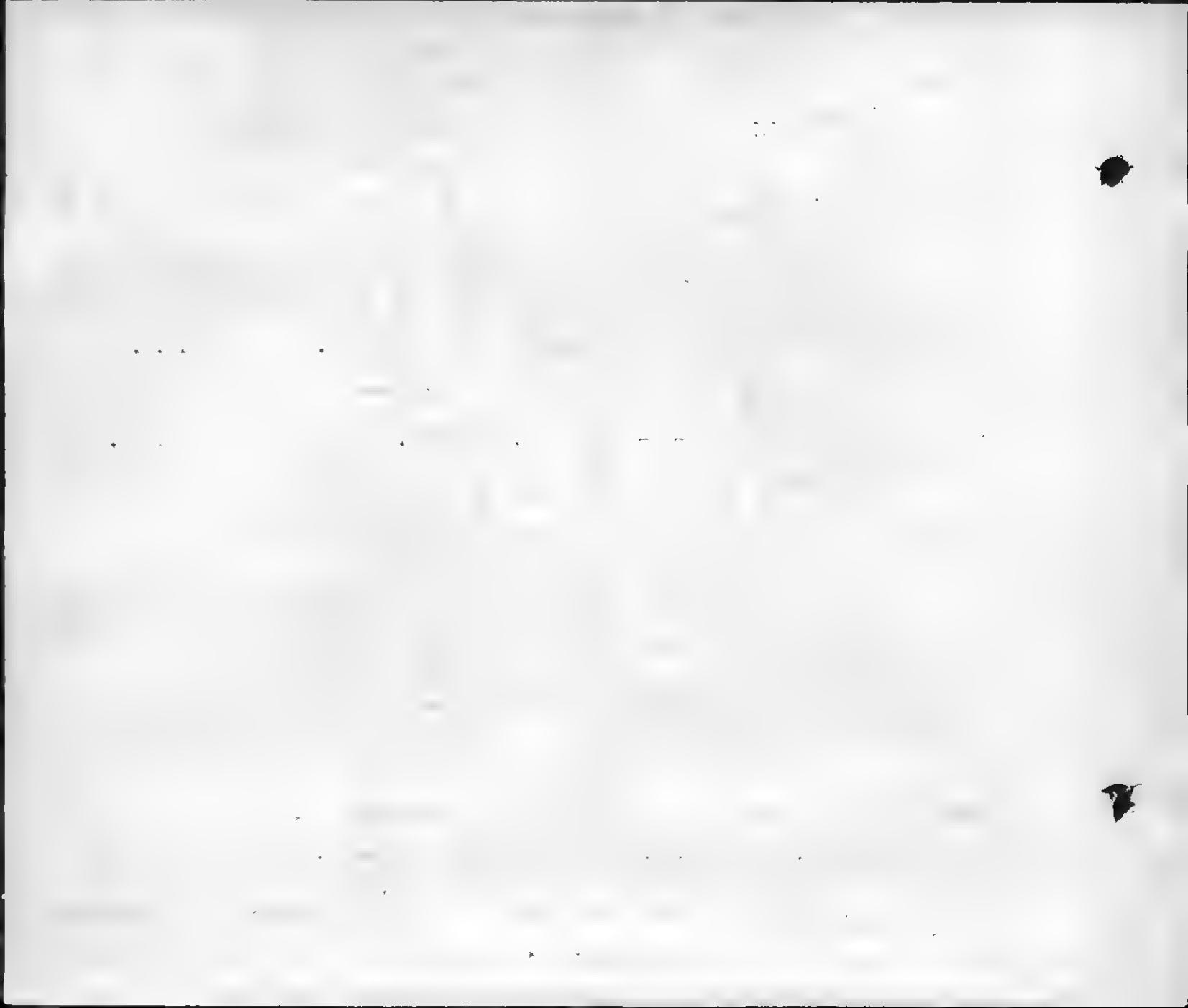
7320

CERTIFICATE OF DEATH

07337
Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 5 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		d. STREET ADDRESS 56 East Franklin Street		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 56 East Franklin Street				d. STREET ADDRESS 56 East Franklin Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) CHARLES		First	Middle	Lost	4. DATE OF DEATH June	Month	Day	Year
5. SEX Male		6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 11, 1890	9. AGE (in years lost birthday) 67 yrs.	10. IF UNDER 1 YEAR Months 11 Days 19	11. IF UNDER 24 HRS. Hours 11 Min. 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Assembly Worker		10b. KIND OF BUSINESS OR INDUSTRY Aircraft Company		11 BIRTHPLACE (State or foreign country) Page County, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Charles Purdham				14. MOTHER'S MAIDEN NAME Susan Pettit				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) no		16. SOCIAL SECURITY NO. 214-09-5459		17. INFORMANT Mrs. Thelma L. Purdham		Address Hagerstown, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		Malnutrition				INTERVAL BETWEEN ONSET AND DEATH 2 WKS		
(b) DUE TO Carcinoma of lung						10-18 mo.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> off work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) Hagerstown		20f. (City or town) Hagerstown		(County) (State)
21. I certify that I attended the deceased from 9-18-1948 to death 1958, that I last saw the deceased alive on 6-29-1958, and that death occurred at 4:10 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE Robert F. Keadle, M.D.						ADDRESS (Street, city or town, state) 318 N. Potomac St.		DATE SIGNED 6-30-58
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/2/1958		22c. NAME OF CEMETERY OR CREMATORIUM Rest Haven Cemetery		22d. LOCATION (City, town, or county) Hagerstown, Maryland		(State)
23. FUNERAL DIRECTOR'S SIGNATURE Superior Funeral Home P. Franklin Berger		ADDRESS Hagerstown, Md.		24a. REC'D. BY REGISTRAR JUL 3 1958		24b. REG. STAR'S SIGNATURE A. Berger		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07338

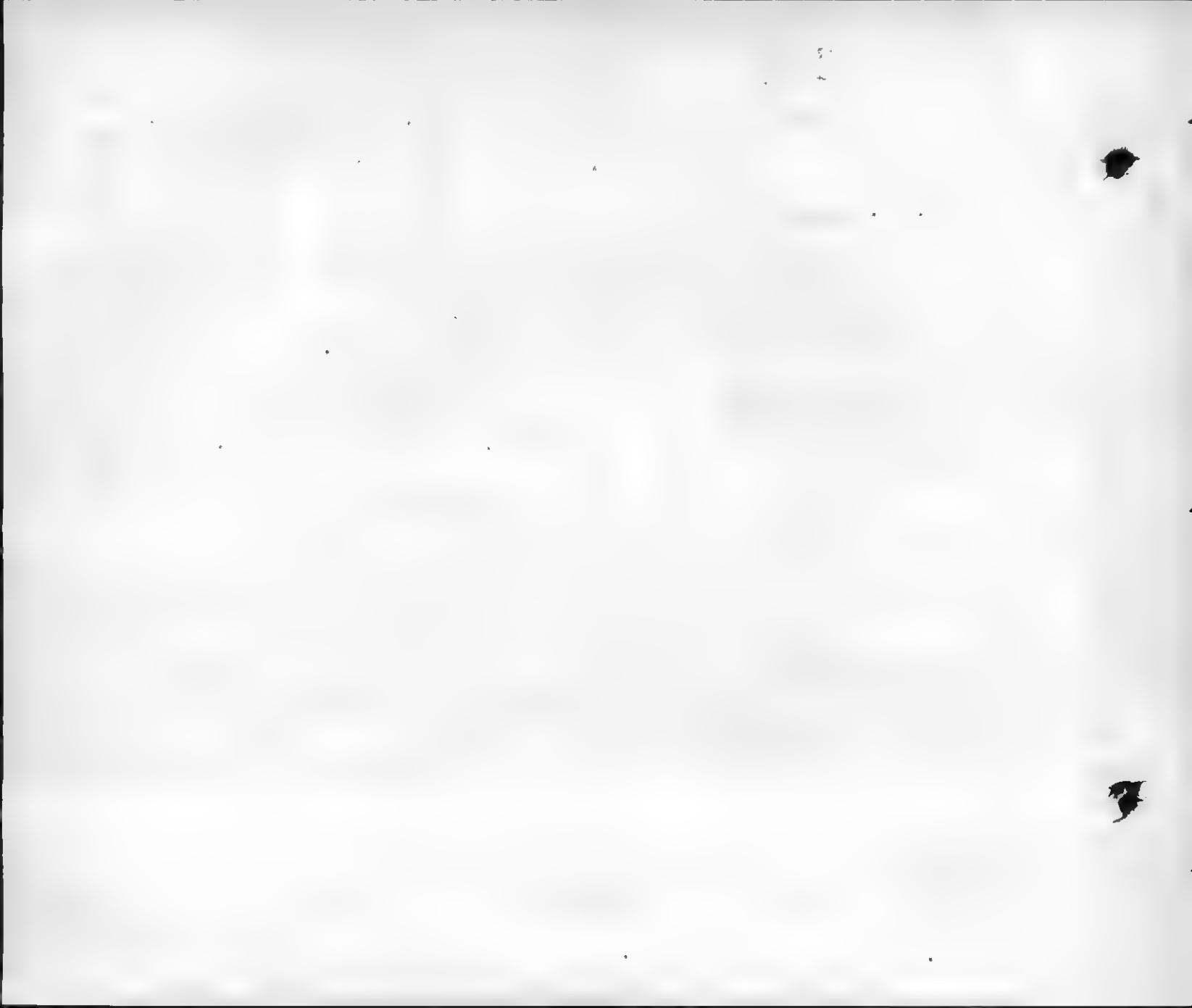
7321

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boonsboro	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. Co. Hospital		e. STREET ADDRESS Route 2	
3. NAME OF DECEASED (Type or print) James		First Middle Franklin	4. DATE OF DEATH 6 Month 3 Day 1958 Year
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 3, 1958
9. AGE (In years last birthday) yrs		10. IF UNDER 1 YEAR Months 3 Days Hours 3 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) infant		10b. KIND OF BUSINESS OR INDUSTRY infant	
11. BIRTHPLACE (State or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Earl Raymond Rager		14. MOTHER'S MAIDEN NAME Shirley Ann Suffecool	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) NO		16. SOCIAL SECURITY NO. none	
17. INFORMANT Earl R. Rager		Address Boonsboro, Md. R2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 76d.5 DUE TO <i>Obstetrics</i> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause first. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 4 hrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Premature Birth</i>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-3, 1958, to 6-5, 1958, that I last saw the deceased alive on 6-3, 1958, and that death occurred at 5:30 P.M., from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED <i>Paul Harrison</i> M.D.			
ACTUAL SIGNATURE			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) burial		22b. DATE THEREOF 6-4-58	
22c. NAME OF CEMETERY OR CREMATORIAL Rose Hill		22d. LOCATION (City, town, or county) Hagerstown (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss		ADDRESS Hagerstown, Md.	
24a. REC'D BY REGISTRAR DATE JUN 4 '58		24b. REGISTRAR'S SIGNATURE <i>Alfred E. Clegg</i>	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7322

CERTIFICATE OF DEATH

417339
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb 1 day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. Co. Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
3. NAME OF DECEASED (Type or print) CHARLES F. RANKIN		First Middle Last Rankin JR.	4. DATE OF DEATH 6 2 19 58
5. SEX male		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 6-1-1958
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) infant		10b. KIND OF BUSINESS OR INDUSTRY infant	9. AGE (In years from birthday) yrs. 11. BIRTHPLACE (State or foreign country) Hagerstown, Md.
13. FATHER'S NAME CHARLES F. RANKIN SR.		14. MOTHER'S MAIDEN NAME MARY ANNA MILLS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) no		16. SOCIAL SECURITY NO. none	17. INFORMANT CHARLES F. RANKIN HAGERST
18. CAUSE OF DEATH [Enter only one cause on line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 76a.s Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any: (b) INURE Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Pulmonary embolism (Hypertension) & edema Pulmonary Congestion & edema Pulmonary embolism (Hypertension) & edema		INTERVAL BETWEEN ONSET AND DEATH 1 day	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 6/1/1958 to 6/2/1958, that I last saw the deceased alive on 6/1/1958, and that death occurred at 8:30 A.M. from the causes and on the date stated above ACTUAL SIGNATURE <i>J. M. Bacon Jr.</i> M.D. ADDRESS (Street, city or town, state) PHYSICIAN'S NAME (Type)		DATE SIGNED 101 King Street Hagerstown 6/2/58 Med.	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 6/4/58	22c. NAME OF CEMETERY OR CREMATORIAL CHAPEL
23. FUNERAL DIRECTOR'S SIGNATURE <i>John T. Clark</i>		ADDRESS CLEAR SPRING, MD.	24a. REC'D BY REGISTRAR DATE JUN 5 '58
		24b. REGISTRAR'S SIGNATURE <i>John Clark</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

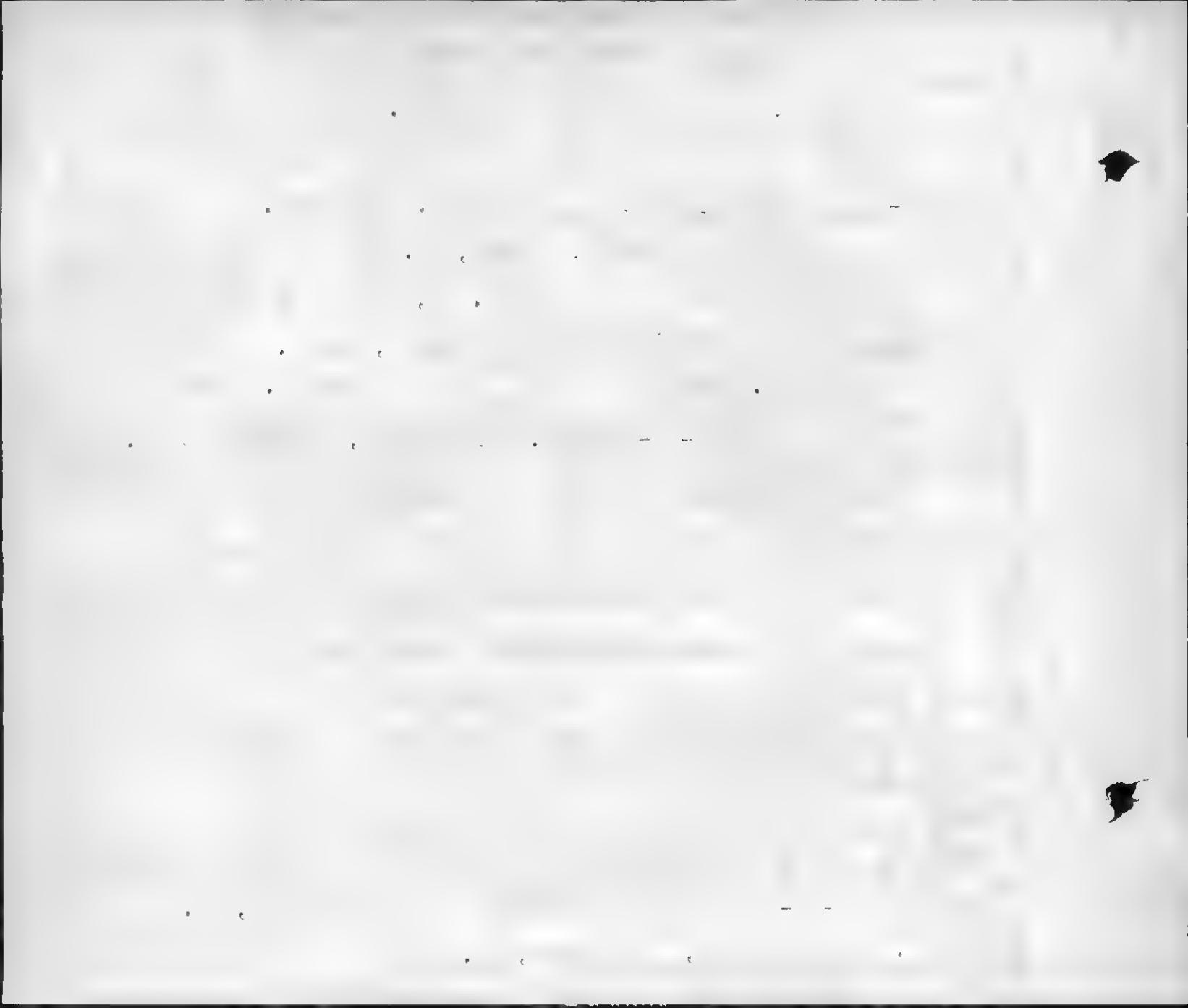
7361

CERTIFICATE OF DEATH

07340

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Mapleville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Fahrney-Keedy Memorial Home		d. STREET ADDRESS 242 E. Irvin Ave.	
3. NAME OF DECEASED (Type or print) John Benedict		First Middle Last	4. DATE OF DEATH Month June Day 9 Year 1958
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 20, 1872
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) bookkeeper		10b. KIND OF BUSINESS OR INDUSTRY retail credit	11. BIRTHPLACE (State or foreign country) Altenwald, Penna.
13. FATHER'S NAME William S. Reed		14. MOTHER'S MAIDEN NAME Anna R. Benedict	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 219-20-1004	17. INFORMANT Address W. Norman Reed, Hagerstown, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) i. 42x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause if any. b) DUE TO c)		INTERVAL BETWEEN ONSET AND DEATH 8 yrs.	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. g. p. m.	19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 6, 1958, to June 7, 1958, that I last saw the deceased alive on June 9, 1958, and that death occurred at 3 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE G. W. Delan M.D. PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-11-58	22c. NAME OF CEMETERY OR CREMATORIY Rose Hill Cemetery	22d. LOCATION (City, town or county) (State) Hagerstown, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE JUN 13 '58	24b. REGISTRAR'S SIGNATURE Alt. each



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07341

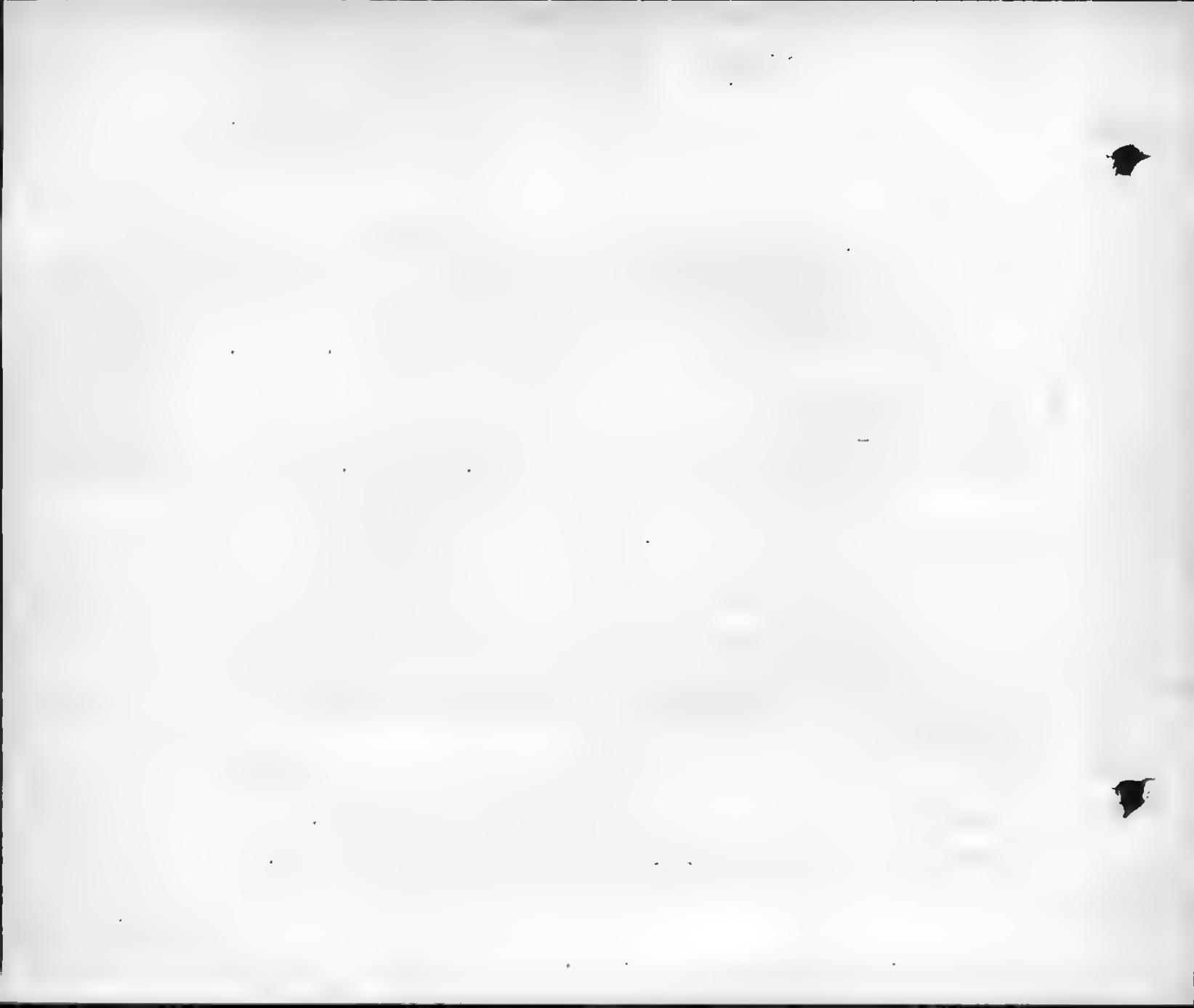
Reg. Dist. No. 505

7323

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician and completely filled in by the funeral director.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb 13 Yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 827 View St		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
3. NAME OF DECEASED (Type or print) ELIZABETH SMITH RIDENOUR		First	Middle
4. DATE OF DEATH June 16 1958	Month	Day	Year 19
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 30 1869
9. AGE (In years lost birthday) 88 yrs	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (State or foreign country) St James Wash. Co Md.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Joseph Smith		14. MOTHER'S MAIDEN NAME Mary Long	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Brayden Ridenour		Address 75 Loller Pkwy	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1X DUE TO Cerebral Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO Cerebral arteriosclerosis (c)		INTERVAL BETWEEN ONSET AND DEATH 9 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/16 1958 to 6/16 1958 that I last saw the deceased alive on 6/16 1958, and that death occurred at 7:30 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Paul Harrison M.D. 318 N. Potomac St.			
DATE SIGNED 6-17-58			
ACTUAL SIGNATURE Paul Harrison		PHYSICIAN'S NAME (Type) Paul Harrison, M. D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/19/58	
22c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery		22d. LOCATION (City, town, or county) Hagerstown Wash Co Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew X. Coffman Hagerstown Md.		24a. REC'D BY REGISTRAR DATE JUN 20 '58	
		24b. REGISTRAR'S SIGNATURE A. Schleicher	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

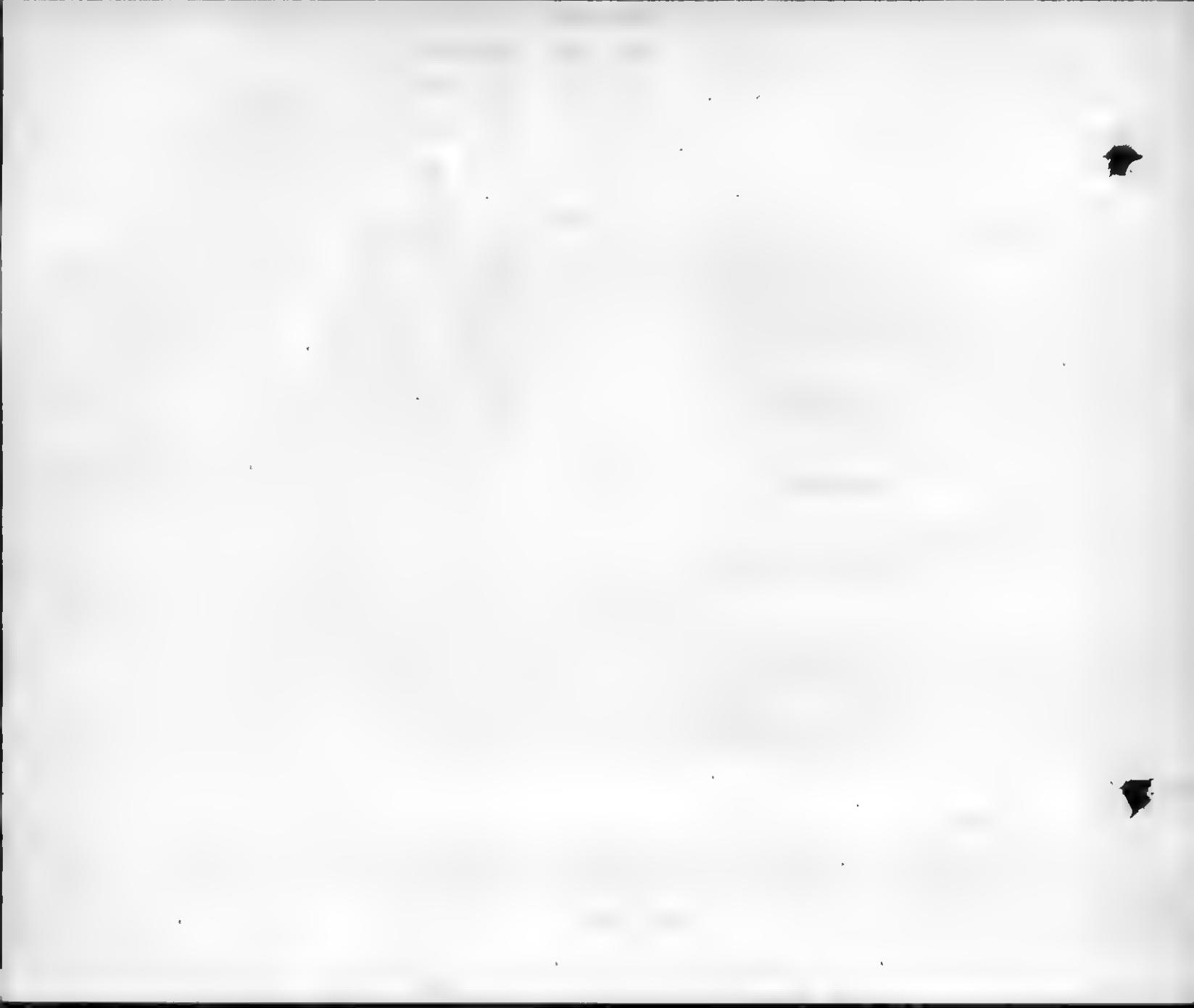
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07342

CERTIFICATE OF DEATH

Reg. Dist. No. 302

7324

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb 41 Yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		d. STREET ADDRESS 431 No Mulberry St		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 431 No Mulberry St				d. STREET ADDRESS 431 No Mulberry St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) MOLLIE		First	Middle	Lost	4. DATE OF DEATH June 6 1958	Month	Day	Year
5. SEX Female		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH June 29 1881	9. AGE (In years last birthday) 76 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Hagerstown Wash. Co		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Frederick Wise		14. MOTHER'S MAIDEN NAME Elizabeth Weaver						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 15-34-4198		17. INFORMANT Mrs Ada Miller 431 No Mulberry St		Address Hagerstown Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		DUE TO		Coronary Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 6 weeks		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)		DUE TO						
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None.						
20c. TIME OF INJURY Hour o. m. p. m.		Month 19	Day	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Hagerstown	(County)	(State)
21. I certify that I attended the deceased from Apr. 25, 1958, to June 6, 1958, that I last saw the deceased alive on June 6, 1958, and that death occurred at 9:50 PM, from the causes and on the date stated above						ADDRESS (Street, city or town, state) 119 North Potomac Street		
ACTUAL SIGNATURE <i>R. A. Bell</i>						DATE SIGNED 6-7-58		
PHYSICIAN'S NAME (Type) R. A. Bell,				Hagerstown, Maryland.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/9/58		22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery		22d. LOCATION (City, town, or county) Hagerstown Wash. Co Md.		(State)
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Cofiran Hagerstown Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE JUN 10 '58		24b. REGISTRAR'S SIGNATURE <i>Ab. Leach</i>		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7362

CERTIFICATE OF DEATH

07343

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Washington Co.</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Washington</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Williamsport</i>		c. LENGTH OF STAY IN 1b <i>1 1/2 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>WILLIAMSPORT</i>		d. STREET ADDRESS <i>154 N. Arizona street</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Williamsport Sanatorium</i>		e. DATE OF DEATH Year <i>June 12 1958</i>		e. DATE OF DEATH Month <i>June</i>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Amanda Jane Scott</i>		First	Middle	Last	Month	Day	Year
4. SEX <i>Female</i>		5. COLOR OR RACE <i>White</i>	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	7. DATE OF BIRTH <i>Jan 24, 1866</i>	8. AGE (in years last birthday) <i>92 yrs</i>	9. IF UNDER 1 YEAR Months <i>6</i>	10. IF UNDER 24 HRS Days <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>OWN HOME</i>		11. BIRTHPLACE (State or foreign country) <i>Hagerstown, Maryland</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13. FATHER'S NAME <i>Peter Hartling</i>		14. MOTHER'S MAIDEN NAME <i>Nancy Baer</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>NONE</i>	
17. INFORMANT <i>MRS. EDNA GROH - HAGERS. R. #2</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>331X</i>		Cerebral Vascular Accident		INTERVAL BETWEEN ONSET AND DEATH <i>1 hr.</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. <i>(b)</i>		DUE TO <i>(c)</i>		Cerebral vascular Disease		3 years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>(County)</i>		(State)	
21. I certify that I attended the deceased from <i>April 1958</i> to <i>12 June 1958</i> , that I last saw the deceased alive on <i>12 June 1958</i> , and that death occurred at <i>8:10 AM</i> from the causes and on the date stated above.		ACTUAL SIGNATURE <i>Paul Haak, M.D.</i>		M.D.		ADDRESS (Street, city or town, state) <i>28 W. Patowmack St. Williamsport, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>6-14-58</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>ROSE HILL CEMETERY</i>		22d. LOCATION (City, town, or county) <i>HAGERSTOWN, MARYLAND</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>ANDREW K. COFFMAN - HAGERSTOWN, MD.</i>		ADDRESS		24a. REC'D BY REGISTRAR <i>JUN 16 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Rebecca</i>	

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to do with it

and what you want

and what you want

point out, etc.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07344

7325 CERTIFICATE OF DEATH

Reg. Dist. No. 80

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 60 Yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 326 No mulberry St				d. STREET ADDRESS 326 No Mulberry St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) HARRY		First	Middle	Lost	4. DATE OF DEATH June 19 1958	Month	Day	Year	
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 11 1874		9. AGE (In years from birthday) 83 yrs	10. IF UNDER 1 YEAR Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Deputy Clerk to Clerk of Court		10b. KIND OF BUSINESS OR INDUSTRY Hagerstown W. sh. Co. Inc.		11. BIRTHPLACE (State or foreign country) Hagerstown W. sh. Co. Inc.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Henry C. Shafer				14. MOTHER'S MAIDEN NAME Martha Rinehart					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-16-0468		17. INFORMANT Mrs Ada H. Shafer 326 No. Mulberry St		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease						INTERVAL BETWEEN ONSET AND DEATH Months			
410.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		None.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m.		Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hagerstown	20f. (City or town) Hagerstown	(County) Wash. Co.	(State) Md.
21. I certify that I attended the deceased from		May 26, 1958		to June 19, 1958		that I last saw the deceased			
alive on		June 19, 1958		and that death occurred at		10:15 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>R. A. Bell</i>						ADDRESS (Street, city or town, state) 119 North Potomac St. Hagerstown, Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/26/58		22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery		22d. LOCATION (City, town, or county) Hagerstown Wash. Co. Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.		ADDRESS				24a. REC'D BY REGISTRAR JUN 26 '58	24b. REG STAR'S SIGNATURE <i>Alt. Reduch</i>		



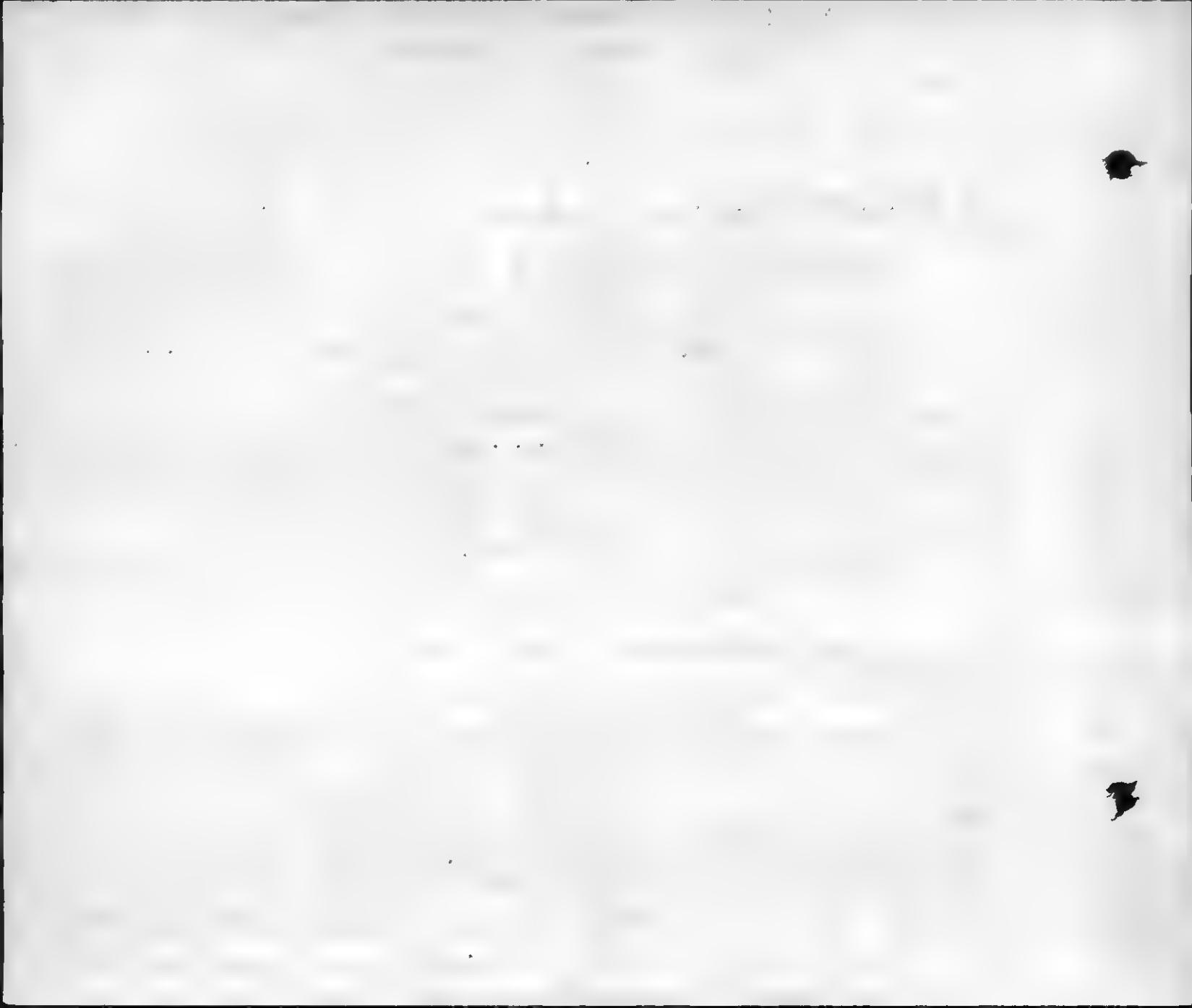
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7326

CERTIFICATE OF DEATH

Reg. Dist. No. 07345

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 22 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
3. NAME OF DECEASED (Type or print) JOHN		First CONRAD	Middle SHERRILL
4. DATE OF DEATH June 14 1958	Month Year	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH July 11, 1888
			9. AGE (In years last birthday) 69 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) President		10b. KIND OF BUSINESS OR INDUSTRY Dry Cleaning	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Charles Sherrill		14. MOTHER'S MAIDEN NAME Virginia Whitener	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 214-09-7967	
17. INFORMANT Mrs. J. C. Sherrill		Address 2500 Virginia Ave. Hagerstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) - 1.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 yrs	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) General Arthritis		19. WAS AN AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, M, from the causes and on the date stated above. ACTUAL SIGNATURE J. H. BEAGHLEY M.D. PHYSICIAN'S NAME (Type)		ADDRESS (Street, city or town, state) Hagerstown, Md. DATE SIGNED JUN 18 '58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/18/58	
22c. NAME OF CEMETERY OR CREMATORIAL Concord Cemetery		22d. LOCATION (City, town, or county) Catawba County, North Carolina. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Inc.		ADDRESS 1601 Penna. Ave. Hagerstown, Md.	
24a. REC'D BY REGISTRAR DATE JUN 18 '58		24b. REGISTRAR'S SIGNATURE W. A. Sharpe C. Pres.	

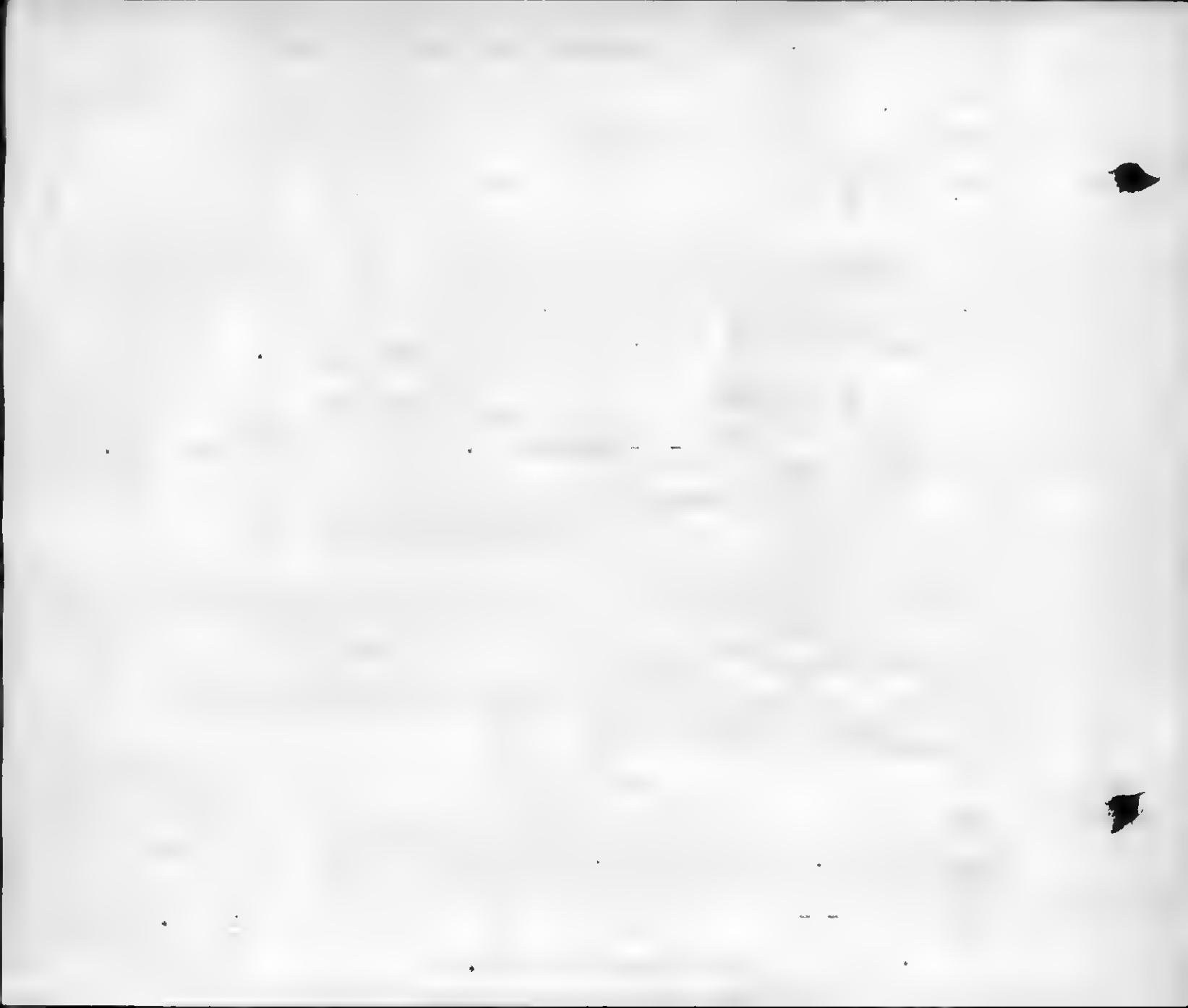


MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
732 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07346

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission.) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		b. COUNTY Washington	
c. LENGTH OF STAY IN lb 3 1/2 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 825 Security Road		d. STREET ADDRESS 825 Security Road	
e. S. RESIDENT ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		e. DATE OF DEATH Month June Day 29 Year 1958	
f. SEX Female		g. COLOR OR RACE White	
h. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		i. DATE OF BIRTH March 10, 1907	
j. AGE (in years last birthday) 51 yrs		k. IF UNDER 1 YEAR Months Days Hours Min	
l. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Looper		m. KIND OF BUSINESS OR INDUSTRY Stocking	
n. BIRTHPLACE (State or foreign country) Fiddlersburg Md.		o. CITIZEN OF WHAT COUNTRY? Hagerstown Md.	
p. FATHER'S NAME James Koontz		q. MOTHER'S MAIDEN NAME Irene Beard	
r. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		s. SOCIAL SECURITY NO. 214-09-4480	
t. INFORMANT Frank T. Smith		u. ADDRESS Hagerstown Md.	
v. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 025X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		w. LUESIC VALVULAR HEART DISEASE RHEUMATIC VALVULAR HEART DISEASE WITH NARROWING OF THE OSTIUM ARTEROSUM	
x. MEDICAL CERTIFICATION None		y. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
z. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		aa. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) None	
ab. TIME OF INJURY Month, Day, Year Hour o. m. None p. m. 19		ac. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
ad. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None		ae. (City or town) (County) (State)	
af. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ag. ACTUAL SIGNATURE <i>S. Robert Wells</i>		ah. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
ai. EXAMINER'S NAME (Type) S. Robert Wells, M.D.		aj. DATE SIGNED 6-30-58	
ak. BURIAL, CREMATION REMOVAL (Specify) Burial		al. DATE THEREOF 7-2-58	
am. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery		an. LOCATION (City, town, or county) Hagerstown Md.	
ao. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son		ap. REC'D BY REGISTRAR DATE JUL 2 '58	
aq. ADDRESS Hagerstown Md.		ar. REGISTRAR'S SIGNATURE <i>W. F. Minnich</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07347

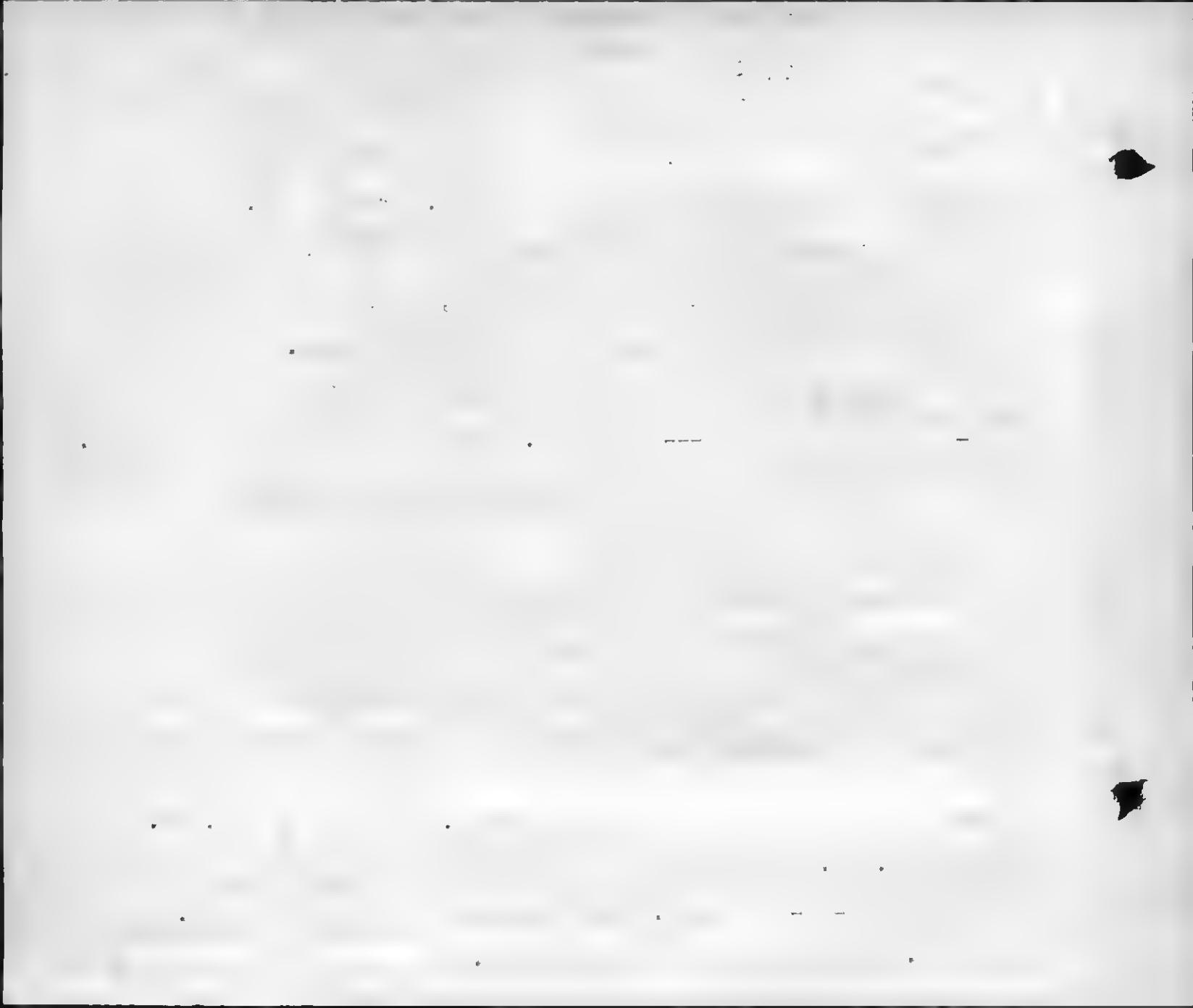
7328

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	c. LENGTH OF STAY IN 1b 29 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		d. STREET ADDRESS 442 E. Franklin St.	
3. NAME OF DECEASED (Type or print) Elizabeth		First Claire	Middle Snavely
4. DATE OF DEATH June	Month	Day 26	Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH April 4, 1882
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Port Perry Penn.		12. CITIZEN OF WHAT COUNTRY? Mary Mc Guire	
13. FATHER'S NAME George Keenan		14. MOTHER'S MAIDEN NAME Mary Mc Guire	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) - - -		16. SOCIAL SECURITY NO. - - -	
17. INFORMANT Mrs. Margaret Bier		Address Mc Kees Rock Pa.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombosis of Internal Carotid Artery DUE TO following Cholecystostomy. Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 24 hrs.	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Generalized Arteriosclerosis.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) - - -	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. - - -	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 25, 1958 to June 26, 1958, that I last saw the deceased alive on June 26, 1958, and that death occurred at 5:00 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE <i>Mrs. Bier</i>		ADDRESS (Street, city or town, state) M.D. 119 N. Potomac St Hag. Md. 6-27-58 DATE SIGNED	
PHYSICIAN'S NAME (Type) R. A. Bell		Hagerstown, Maryland.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-30-58	22c. NAME OF CEMETERY OR CREMATORIUM Mt. View Cemetery	22d. LOCATION (City, town, or county) Sharpsburg Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son		ADDRESS Hagerstown Md.	24a. REC'D BY REGISTRAR DATE 158
			24b. REGISTRAR'S SIGNATURE <i>Allie Deuch</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

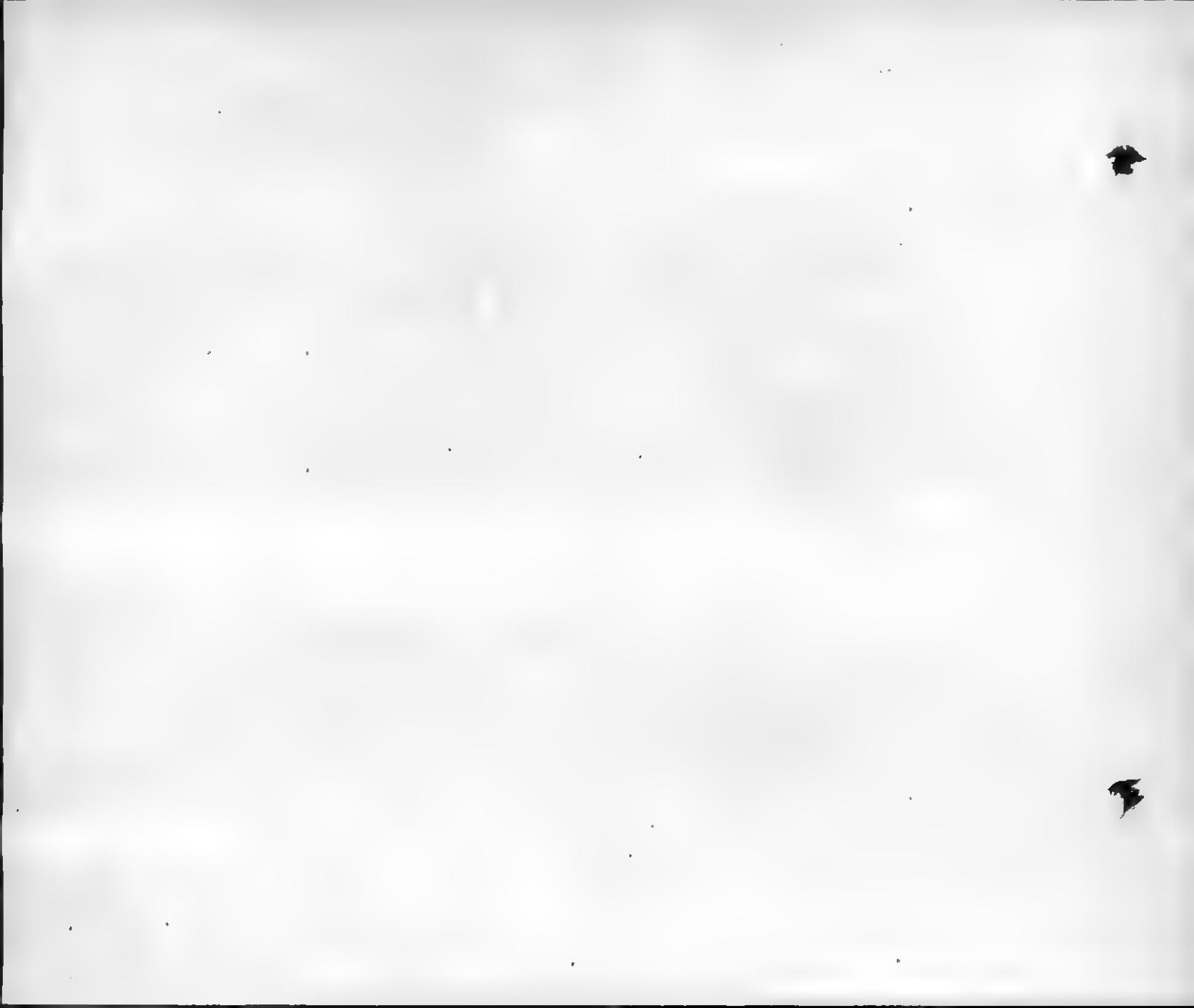
7329

CERTIFICATE OF DEATH

07348
503

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington Maryland		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	c. LENGTH OF STAY IN 1b 4 Mos	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	d. STREET ADDRESS 409 Ridge Ave
d. NAME OF HOSPITAL (If not in hospital, give street address) Mash. County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARGARET	First ODA	Middle SNODDERLY	4. DATE OF DEATH June 11 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 20 1907
9. AGE (In years last birthday) 50 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Hagerstown Wash. Co Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Frush		14. MOTHER'S MAIDEN NAME Margaret Loudenslager	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. <input type="text"/> 17. INFORMANT Ernest P. Snodderly 409 Ridge Ave Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)		19. INTERVAL BETWEEN ONSET AND DEATH Hagerstown L.D. Leukemia Gronblod 18 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March</u> , 19 <u>58</u> , to <u>June 11</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11 June</u> , 19 <u>58</u> , and that death occurred at <u>6:55 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>John D. Hoachlander</i>		ADDRESS (Street, city or town, state) <i>115 W. Washington</i> DATE SIGNED <i>6/13/58</i>	
PHYSICIAN'S NAME (Type) <i>John D. Hoachlander</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/14/58	22c. NAME OF CEMETERY OR CREMATORIY Rest Haven Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown Wash. Co Md.
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.		24a. REC'D BY REGISTRAR DATE JUN 16 '58	
		24b. REGISTRAR'S SIGNATURE <i>John E. Coffman</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7.330

CERTIFICATE OF DEATH

Reg. Dist. No. 302

07341

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 4 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
3. NAME OF DECEASED (Type or print) IVA		First MYRTIE	Middle SOCKS
4. DATE OF DEATH June		Month June	Day 20
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
		WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH June 16, 1903		9. AGE (in years from birthday) 55	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months 55
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tavern Owner		10b. KIND OF BUSINESS OR INDUSTRY Own Business	11. BIRTHPLACE (State or foreign country) Hagerstown, Md.
13. FATHER'S NAME Joseph R. Mounshower		14. MOTHER'S MAIDEN NAME Minnie Blizzard	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or no or unknown) no		16. SOCIAL SECURITY NO. 218-30-9534	17. INFORMANT Address Jack R. Socks Hagerstown, Maryland
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 199.2		INTERVAL BETWEEN ONSET AND DEATH 1 week	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		UREMIA	
METASTATIC CARCINOMA		3 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II if item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 6/13 1958
20f. (City or town) 6/13 1958		(County) (State)	
21. I certify that I attended the deceased from 6/20 1958 to 6/20 1958 , that I last saw the deceased alive on 6/20 1958 , and that death occurred at 4:55 AM from the causes and on the date stated above.			
ACTUAL SIGNATURE D. J. Boyer		ADDRESS (Street, city or town, state) 135 No. 1st St Hagerstown, Maryland	
PHYSICIAN'S NAME (Type) D. J. Boyer		DATE SIGNED 6/20/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/23/1958	22c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery
22d. LOCATION (City, town, or county) Hagerstown, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Suter-Holzer Funeral Home		ADDRESS Hagerstown, Md.	
24a. REC'D BY REGISTRAR JUN 23 1958		24b. REGISTRAR'S SIGNATURE Alt. Leibach	
DATE			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07351

7331

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Penna. b. COUNTY Franklin	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waynesboro	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Martin Manor Rest Home		d. STREET ADDRESS 14 West North Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First HARRY	Middle B.	Last SPECK
4. DATE OF DEATH	Month June	Day 6	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Jan. 1, 1867
		9. AGE (in years from birth to death) 91 yrs	
		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY self-employed	
11. BIRTHPLACE (State or Foreign country) Penns.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frederick Speck		14. MOTHER'S MAIDEN NAME Emma Hay	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. None	
17. INFORMANT		Address Charles D. Speck, 14 W. North St., Waynesboro, Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 142.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Benign Prostate hypertrophy, gynaec. Atherosclerosis & distance		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part II if from Part I) ADDRESS (Street, city or town, state)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Apr 17, 1958</u> , to <u>June 6, 1958</u> , that I last saw the deceased alive on <u>June 4, 1958</u> , and that death occurred at <u>3:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Edward W. Ditto III</u> M.D. 217 W. Washington Street			
22a. PHYSICIAN'S NAME (Type) <u>Edward W. Ditto III, M.D.</u>		22b. DATE THEREOF <u>6/6/58</u>	
22c. NAME OF CEMETERY OR CREMATORIUM <u>Green Hill Cemetery</u>		22d. LOCATION (City, town, or county) <u>Waynesboro</u> (State) <u>Penna.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Martin Roe</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 9 '58</u>	
ADDRESS <u>Waynesboro, Penna.</u>		24b. REGISTRAR'S SIGNATURE <u>John E. Schuck</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

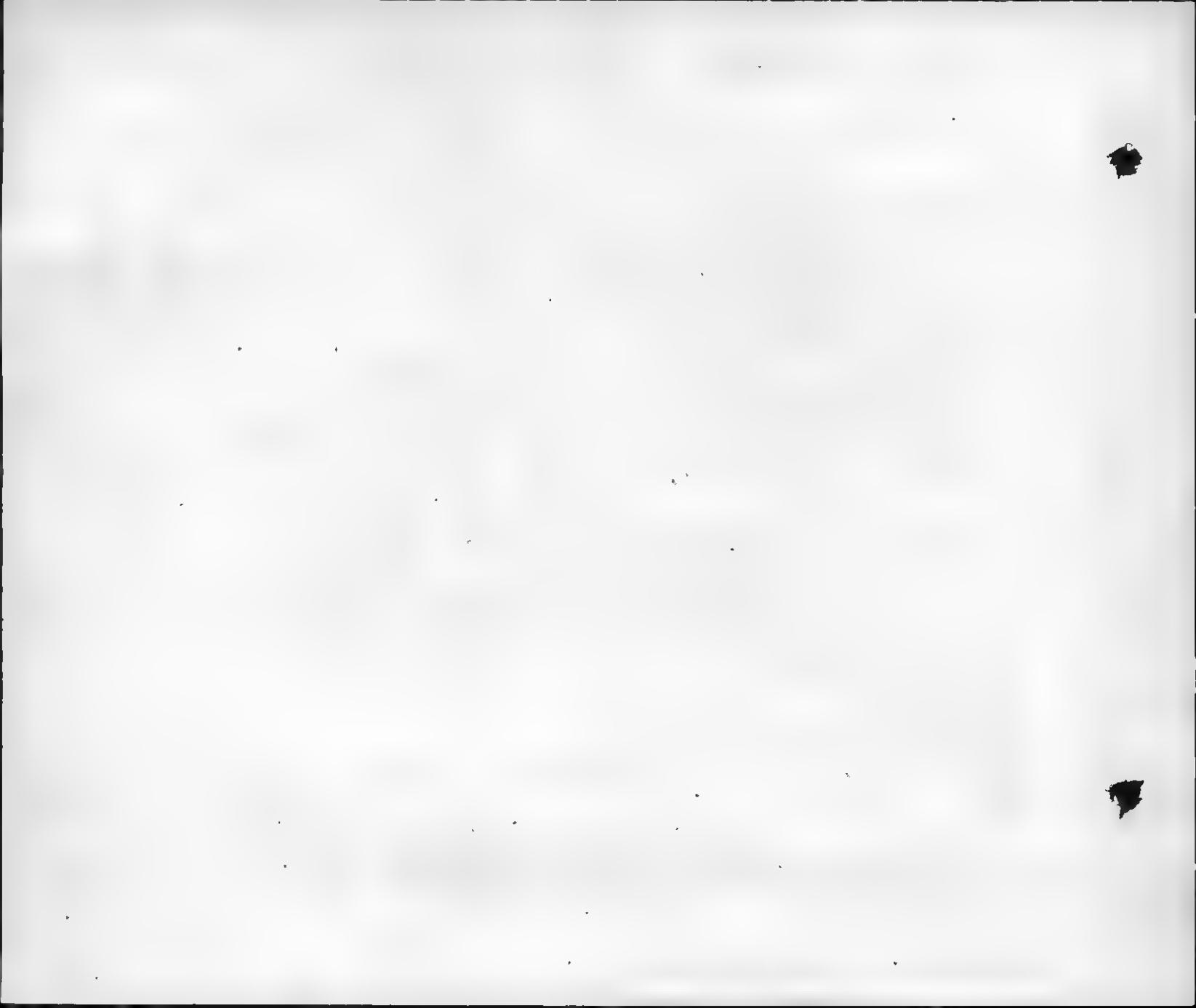
7363

CERTIFICATE OF DEATH

Reg. Dist. No.

07351

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) b. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown R # 4		c. LENGTH OF STAY IN 1b 11 Yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Broadfording Road		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown L 4	
3. NAME OF DECEASED (Type or print) HARVEY		First MIDDLE OSCAR	4. DATE OF DEATH June 25 1958
S SEX Male	COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	5. DATE OF BIRTH May 8 1877
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer Retired		10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (State or foreign country) Cearfoss Wash. Co Md.
13. FATHER'S NAME Franklin Spickler		14. MOTHER'S MAIDEN NAME Katherine Garner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None	17. INFORMANT Mrs Lillian P. Spickler Hagerstown R # 4 Broadfording Rd
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 6-1-1956 to 6-25-1956, that I last saw the deceased alive on 6-23-1956, and that death occurred at 7 PM, from the causes and on the date stated above		ADDRESS (Street, city or town, state) Hagerstown Md.	
ACTUAL SIGNATURE Physician's Name (Type) Andrew K. Coffman		DATE SIGNED 6/26/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/28/58	22c. NAME OF CEMETERY OR CREMATORIUM Rest Haven Cemetery
22d. LOCATION (City, town, or county) Hagerstown Wash. Co Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.		24a. REC'D BY REGISTRAR DATE JUN 30 '58	24b. REGISTRAR'S SIGNATURE C. S. Smith



may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

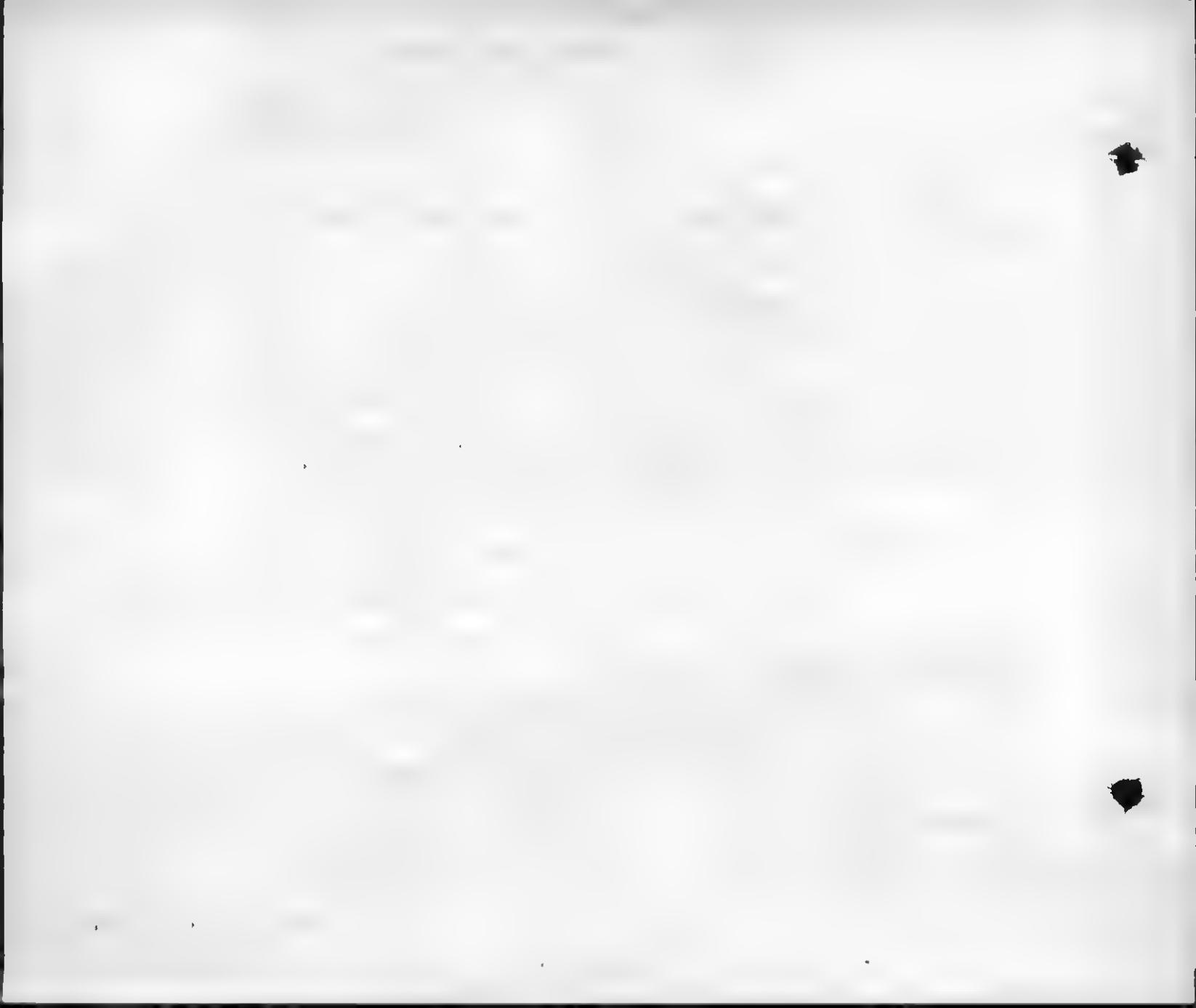
7364

CERTIFICATE OF DEATH

07352

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown R # 6		c. LENGTH OF STAY IN 1b 20 Yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown R # 6		d. STREET ADDRESS Millers Church Road			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Millers Church Road				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) DAVID		First	Middle	Lost	4. DATE OF DEATH June 24 1958	Month	Day	Year	
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 16 1871	9. AGE (In years last birthday) 86	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	Hours	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer- Retired		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) near Leitersburg Wash		12. CITIZEN OF WHAT COUNTRY Co USA			
13. FATHER'S NAME John A. Strite		14. MOTHER'S MAIDEN NAME Katherine Maun							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Charles E. Strite 846 Summit Ave		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 42 in 2		DUE TO Congestive Heart Failure		Hagerstown L.D.		INTERVAL BETWEEN ONSET AND DEATH 1 hour			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		DUE TO Myocardial Insufficiency				6 mos.			
(c)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) May 18		20f. (City or town) Hagerstown		(County) Washington	(State) Md.
21. I certify that I attended the deceased from alive on May 18, 1958		to May 18, 1958		that I last saw the deceased and that death occurred at 6 AM , from the causes and on the date stated above		ADDRESS (Street, city or town, state) 135 N Potomac St.		DATE SIGNED	
ACTUAL SIGNATURE <i>J. D. Wilson</i>		PHYSICIAN'S NAME (Type) J. D. Wilson, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/27/58		22c. NAME OF CEMETERY OR CREMATORIUM Lutheren Cemetery		22d. LOCATION (City, town, or county) Leitersburg Wash. Co. Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown L.D.		ADDRESS		24e. REC'D BY REGISTRAR DATE JUN 26 '58		24f. REGISTRAR'S SIGNATURE W. L. Smith			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07353

Reg. Dist. No.

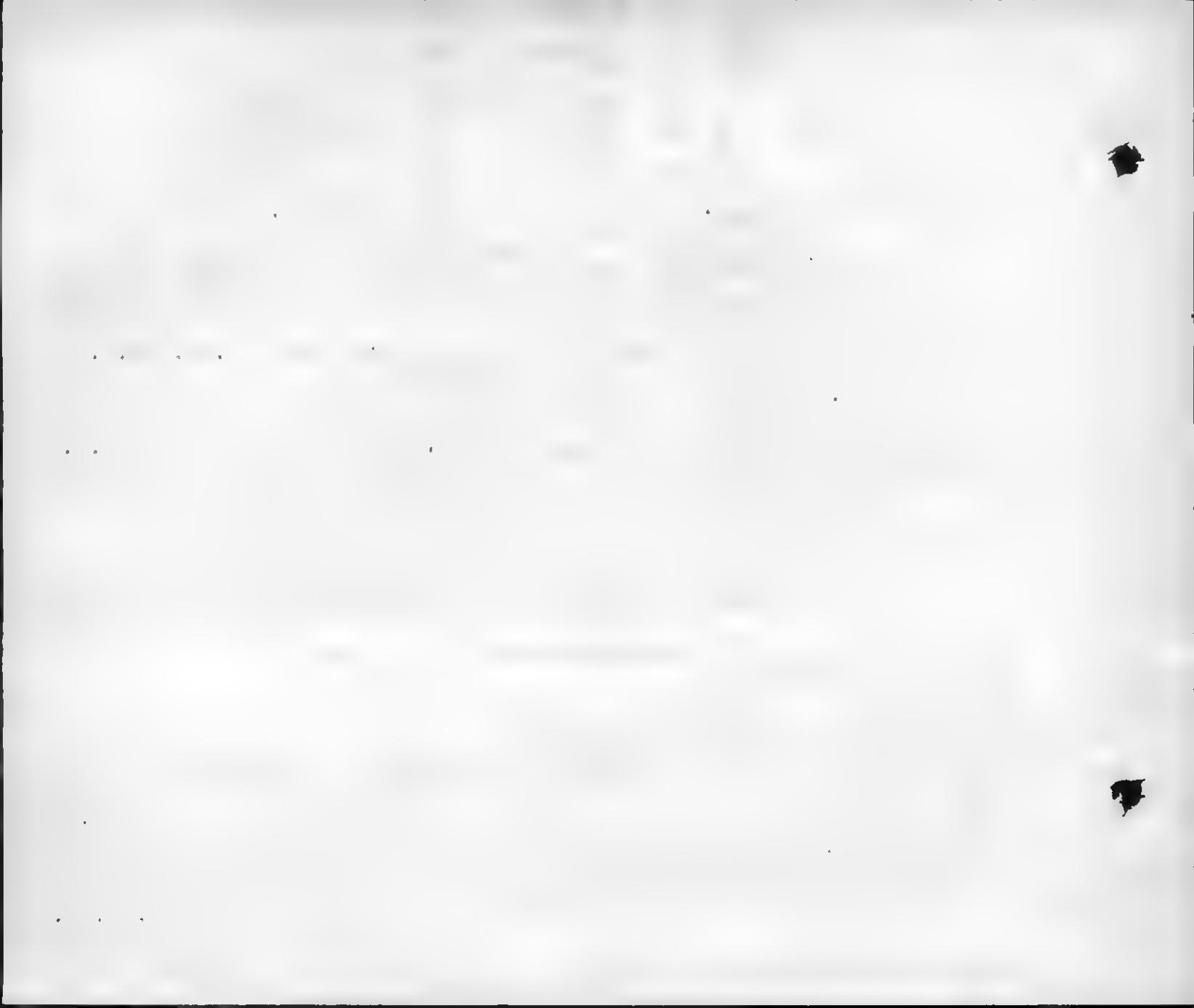
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Dr. de Van

VS A15 (4)
15M 10/57

PLACE OF DEATH o COUNTY WASHINGTON		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o STATE MARYLAND		b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL		c. LENGTH OF STAY IN 16 31 YEARS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL		d. STREET ADDRESS ROHRERSVILLE MD.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ROHRERSVILLE MD.						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GENEVA		First MIDDLE SARAH		4. DATE OF DEATH JUNE 9 1958		Month Day Year 1958	
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 3 1878	
		WIDOWED <input checked="" type="checkbox"/>		DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) 80 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) BEAVER CREEK WASH.CO. MD.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME JOHN W. LUNG		14. MOTHER'S MAIDEN NAME AMELIA BISHOP		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.		17. INFORMANT CHARLES V. SUMMERS ROHRERSVILLE MD. R. 1		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 44-X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. b) DUE TO c)	
						INTERVAL BETWEEN ONSET AND DEATH 8 yrs	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 6, 1958, to June 9, 1958, that I last saw the deceased alive on June 6, 1958, and that death occurred at 7116, from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE G. W. Lelias PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVED BURIAL JUNE 12 1958		22b. DATE THEREOF JUNE 12 1958		22c. NAME OF CEMETERY OR CREMATORIUM LUTHERAN CEMETERY		22d. LOCATION (City, town, or county) BEAVER CREEK WASH.CO. MD. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Baert Funeral Home Bethesda Md.		ADDRESS		24a. REC'D. BY REGISTRAR DATE JUN 13 '58		24b. REGISTRAR'S SIGNATURE A. Leach	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7332

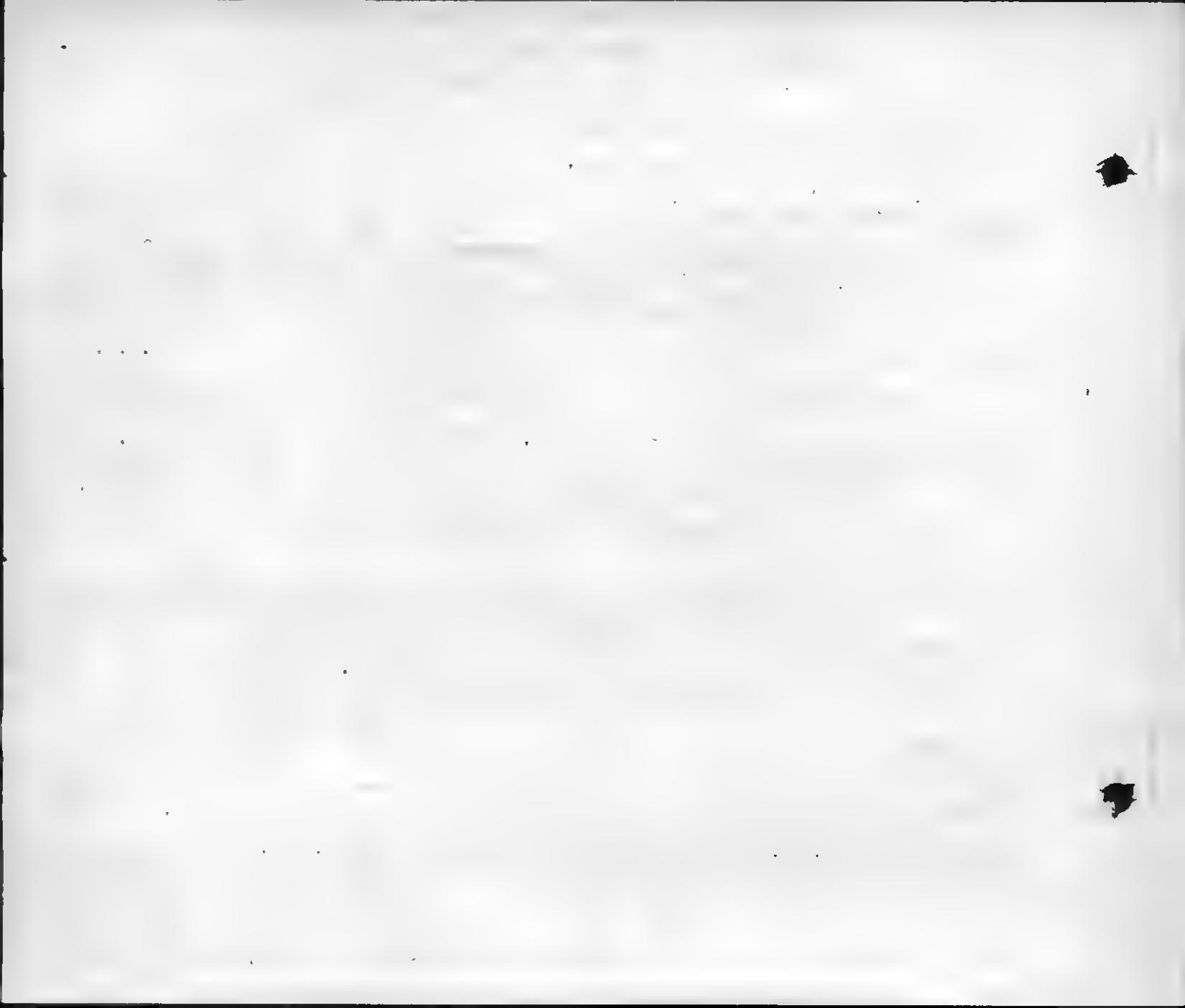
CERTIFICATE OF DEATH

Reg. Dist. No. 302

07354
302

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		b. COUNTY Maryland		
c. LENGTH OF STAY IN lb 2 yrs 9 mos.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		d. STREET ADDRESS 243 West Side Avenue		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First MORRIS	Middle Sheppard	Last TURBYFILL	
4. DATE OF DEATH	Month June	Day 10	Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 22 1906	
9. AGE (in years last birthday) 51	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0	
13a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foundry Foreman	10b. KIND OF BUSINESS OR INDUSTRY Foundry	11. BIRTHPLACE (State or foreign country) Texas	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lewis Turbyfill	14. MOTHER'S MAIDEN NAME Docey Williams			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 228-05-7740	17. INFORMANT Mrs. Verine R. Turbyfill	24. ADDRESS 243 West Side Ave Hagerstown Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage			INTERVAL BETWEEN ONSET AND DEATH 6 hr.	
DUE TO Conditions, if any, which gave rise to immediate cause (a), listing the under- lying cause (b). DUE TO Hypertensive vascular disease			Indefinite	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Chronic glomerular nephritis			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from March 7, 1957 to June 18, 1958 that I last saw the deceased alive on June 17, 1958 , and that death occurred at 3:50 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 148 West Washington St. 6/18/58				
ACTUAL SIGNATURE <i>B. B. Kneisley</i>		DATE SIGNED 6/18/58		
PHYSICIAN'S NAME (Type) B. B. Kneisley		Hagerstown, Md.		
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 6/18/58	22c. NAME OF CEMETERY OR CREMATORIUM Maury Cemetery	22d. LOCATION (City, town, or county) (State) Richmond Virginia
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles Mayes</i>		ADDRESS <i>Hagerstown Maryland</i>	24a. REC'D BY REGISTRAR DATE JUN 20 '58	24b. REGISTRAR'S SIGNATURE <i>DeLoach</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

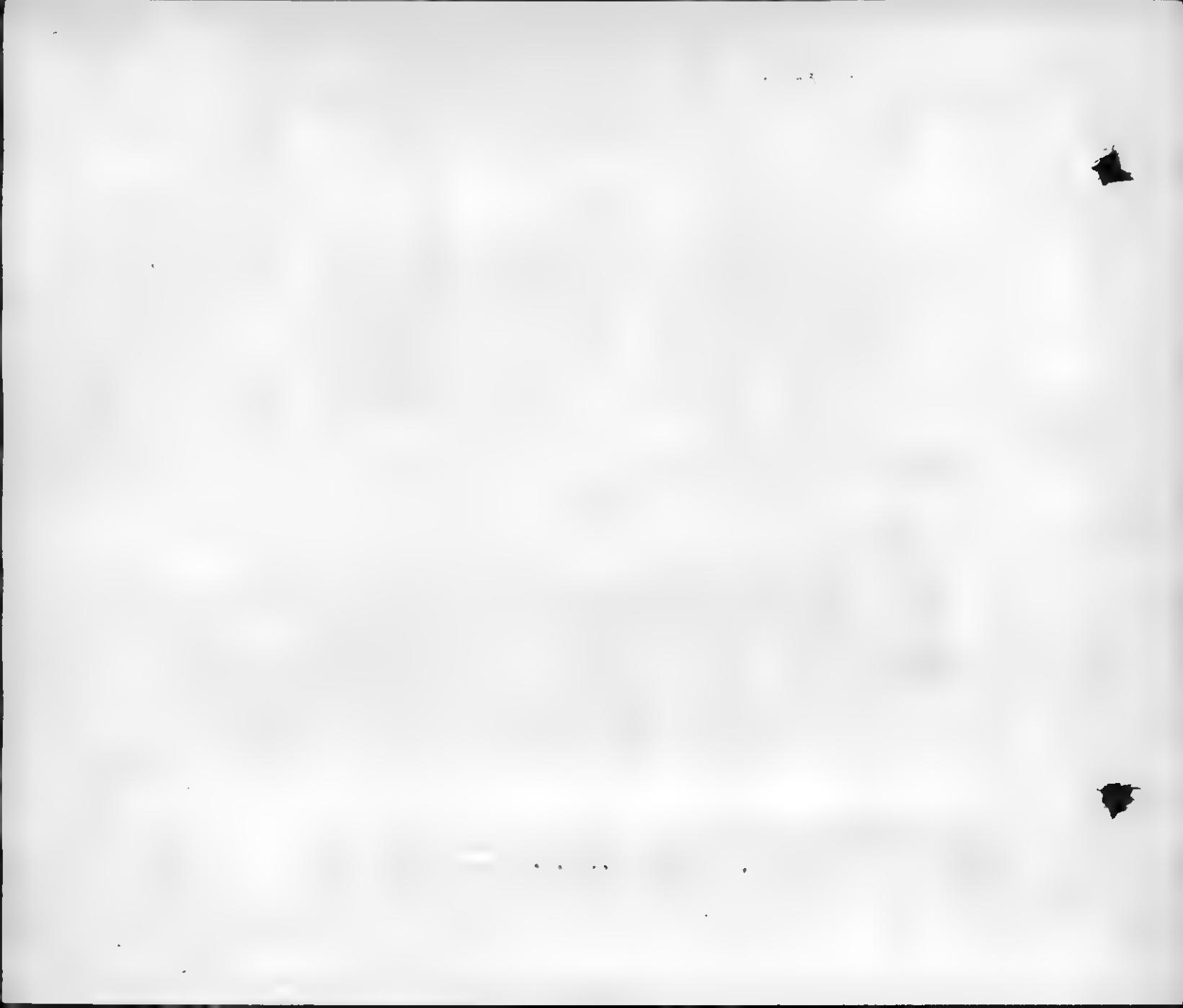
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for future files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Health Dept. or its designated agent, prior to burial, cremation, or removal, and it can be used within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7333 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09580

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Calvert		2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) b. STATE Maryland c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 328 Blooms Court		e. STREET ADDRESS 328 Blooms Court	
f. IS RE BURIAL ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Betty	First ANN	Middle TWYMAN	4. DATE OF DEATH June 16, 1958
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> April 13, 1955	9. AGE (in years from birthday) 3 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME James Harrison Twyman		14. MOTHER'S MAIDEN NAME Dorothy Virginia Jenkins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Undetermined</u> 795.5 DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE <i>William V. Lovitt</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 6/17/58
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.	22a. NAME OF CEMETERY OR CREMATORIUM U. of Med. Med. School		22b. LOCATION (City, town, or county) Baltimore, Md. (State)
22c. DATE THEREOF 8. 22.58	24a. REC'D BY REGISTRAR DATE AUG 2 6 '58		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>
23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7334

CERTIFICATE OF DEATH

Reg. Dist. No.

07355

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 949 Maryland Ave.		d. STREET ADDRESS 949 Maryland Ave.	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First JOHN	Middle WILLIAM	Last UNSELD	4. DATE OF DEATH June 11 1958
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH June 9, 1881	9. AGE (In years lost birthday) 77 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. IF UNDER 24 HRS. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY Railroad	11. BIRTHPLACE (State or foreign country) West Virginia	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13. FATHER'S NAME James Unseld	14. MOTHER'S MAIDEN NAME Nettie Croft
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 719-07-6659	17. INFORMANT Mrs. J. W. Unseld	Address 949 Maryland Ave. Hagerstown, Md.
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)	INTERVAL BETWEEN ONSET AND DEATH 1 yrs
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MEDICAL CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21. I certify that I attended the deceased from 5/11/58, 19, to 6/13/58, 19, that I last saw the deceased alive on 6/11/58, 19, and that death occurred at 10 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE Edward W. Ditto, M.D. PHYSICIAN'S NAME (Type) Edward W. Ditto, M.D., Hagerstown, Maryland	ADDRESS (Street, city or town, state) 217 W. Washington Street DATE SIGNED 6/13/58
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22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/14/58	22c. NAME OF CEMETERY OR CREMATORIAL Rest Haven Cemetery	22d. LOCATION (City, town, or county) Hagerstown (State) Md.
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23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Inc.	ADDRESS 1601 Penna. Ave. Hagerstown, Md.	24a. REC'D BY REGISTRAR DATE JUN 13 58	24b. REGISTRAR'S SIGNATURE W. E. D.
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THIS ATTENDING PHYSICIAN: Title I am required that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7366

CERTIFICATE OF DEATH

Reg. Dist. No. 07356

1. PLACE OF DEATH a. COUNTY		Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		a. STATE	b. COUNTY
Rural Big Pool Md.		15 Yrs.		Maryland	Washington
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Home		Big Pool Md.			
3. NAME OF DECEASED (Type or print)		First	Middle	Lost	4. DATE OF DEATH
Kenneth		Charles	Vance		Month 6 Day 3 Year 1958
5. SEX	6. COLOR OR RACE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8 DATE OF BIRTH	9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR Months 3 Days 21 Hours 0 Min
M	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Bob. 9. 1892	66	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Farming Retired		Farming		Washington County Md.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Clarence C Vance		Ruth Rhoda Shives		U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or no or unknown) <input type="checkbox"/> NO		16. SOCIAL SECURITY NO.		17. INFORMANT	
		220-30-9226		Retha S Vance Big Pool Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Acute Coronary Disease			
420.1 DUE TO		4 days			
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause, if any. (b)					
DUE TO					
(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1, 1958, to June 3, 1958, that I last saw the deceased alive on June 3, 1958, and that death occurred at 71 M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state)			
ACTUAL SIGNATURE David R. Brewer		DATE SIGNED 6/5/58			
PHYSICIAN'S NAME (Type) David R. Brewer					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6.6.58		22c. NAME OF CEMETERY OR CREMATORIAL St. Paul's Cemetery	
22d. LOCATION (City, town, or county) St. Paul's Washington Md.					
23. FUNERAL DIRECTOR'S SIGNATURE Howard & Son Hanover Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE JUN 9 '58	
				24b. REGISTRAR'S SIGNATURE Al. Lewis	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the offending physician and completely filled in by him, it may be filed with page 3 should be attached for use as the burial-trouism permit. Then please remove carbon paper. Pages 1 and 2 may be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be attached for use as the burial/transit permit. Then, please remove carbon paper. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 302

07357

7335

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Baltimore							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 1216 W. 40th Street							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)	First Mamie	Middle Ware	Last Ware	4. DATE OF DEATH June	Month June	Day 29	Year 1958						
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH February 22, 1896	9. AGE (In years last birthday) 62 yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months 4 Days 7 Hours 0 Min. 0								
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Hugh Doyle				14. MOTHER'S MAIDEN NAME Cora Leppo									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT		Address							
						Mrs. Caroline Herchenrother Smithsburg, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]													
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Metastatic Cancer INTERVAL BETWEEN DUE TO 1 yr ONSET AND DEATH													
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Cancer of breast 5 yrs DUE TO (c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from June 13, 1958 to June 29, 1958 , that I last saw the deceased alive on June 29, 1958 , and that death occurred at 11:50 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 214 N. Potomac St. (Funeral) DATE SIGNED Lloyd A. Fine													
ACTUAL SIGNATURE Lloyd A. Fine		22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial						22b. DATE THEREOF 7/2/1958		22c. NAME OF CEMETERY OR CREMATORIUM Wesley Cemetery		22d. LOCATION (City, town, or county) Hampstead, Maryland (State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Myers Funeral Home		ADDRESS Westminster, Maryland		24a. REC'D BY REGISTRAR DATE JUL 3 '58		24b. REGISTRAR'S SIGNATURE Asst. Reg.							



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07358

7336

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	c. LENGTH OF STAY IN 16 5 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 3 Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garlock Nursing Home, 241 S. Prospect.		d. STREET ADDRESS 666 N. Prospect St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Grace	Middle C.	Last Waters
4. DATE OF DEATH June 6 1958	Month June	Day 6	Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 12, 1885
			9. AGE (In years lost, birthday) 72 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Auburn Nebraska		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Blessing		14. MOTHER'S MAIDEN NAME Mary Routzahn	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) no		16. SOCIAL SECURITY NO. 17. INFORMANT none Mr. James A. Waters, 666 N. Prospect St. Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Carcinoma of Colon.		INTERVAL BETWEEN ONSET AND DEATH Months	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) None.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Apr. 23, 1958, to June 6, 1958, that I last saw the deceased alive on June 5, 1958, and that death occurred at 9:45 A.M., from the causes and on the date stated above ACTUAL SIGNATURE <i>R. A. Bell</i> ADDRESS (Street, city or town, state) DATE SIGNED M.D. 119. North Potomac St. 6-7-58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 9, 1958	
22c. NAME OF CEMETERY OR CREMATORIAL Lutheran		22d. LOCATION (City, town, or county) Middletown, Fred. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Paul F. Bittle</i>		ADDRESS Paul F. Bittle, Myersville, Md.	
		24a. REC'D BY REGISTRAR DATE JUN 10 '58	
		24b. REGISTRAR'S SIGNATURE <i>Alfred J. Schuch</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 to be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07359

7337

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Washington</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>HAGERSTOWN</i>		c. LENGTH OF STAY IN lb <i>4 Month</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>WESTERN MD STATE HOSPITAL</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>HANCOCK</i>	
3. NAME OF DECEASED (Type or print) <i>CHARLES</i>		d. STREET ADDRESS <i>Tolifer Avenue</i>	
4. DATE OF DEATH <i>JUNE 23 1958</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>MALE</i>		6. COLOR OR RACE <i>White</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>JULY 11, 1879</i>	
9. AGE (In years last birthday) <i>78 yrs.</i>		10. IF UNDER 1 YEAR Months Days Hours Min. 0 0 0 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>TRUCK DRIVER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Railroad</i>	
10c. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>UNITED STATES</i>	
13. FATHER'S NAME <i>CHARLES A. WEAVER, SR.</i>		14. MOTHER'S MAIDEN NAME <i>SARAH JANE Myers</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>NO</i>		16. SOCIAL SECURITY NO (If yes, give war or dates of service)	
17. INFORMANT <i>Mrs. Robert WEAVER, -HANCOCK, Md.</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>TECHNICAL LOBULAR BRONCHOPNEUMONIA</i> DUE TO <i>2 weeks</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost (b) DUE TO <i>PULMONARY EDEMA AND CONGESTION</i> (c) <i>5 days</i> <i>BILATERAL PULMONARY EMPHYSEMA</i> <i>15 years</i>	
19. WAS AUTOPSY PERFORMED? <i>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></i>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a) <i>ADRENAL INSUFFICIENCY - INACTIVE PULMONARY TUBERCULOSIS</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>JUN 24 1958</i> to <i>JUN 23 1958</i> , that I last saw the deceased alive on <i>JUN 22 1958</i> , and that death occurred at <i>3:45 AM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Ernesto P. Lardizabal</i> M.D. ADDRESS (Street, city or town, state) <i>1500 Pennsylvania Ave.</i> DATE SIGNED PHYSICIAN'S NAME (Type) <i>Ernesto P. Lardizabal</i> <i>Hagerstown, Md.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6-26-58</i>	
22c. NAME OF CEMETERY OR CEMETORY <i>Stone Bridge</i>		22d. LOCATION (City, town, or county) <i>near Howard Washington rd</i> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Howard J. Linn, Howard J. Linn, Md.</i>		24a. REC'D BY REGISTRAR DATE JUN 25 '58	
		24b. REGISTRAR'S SIGNATURE <i>Albert</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
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the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

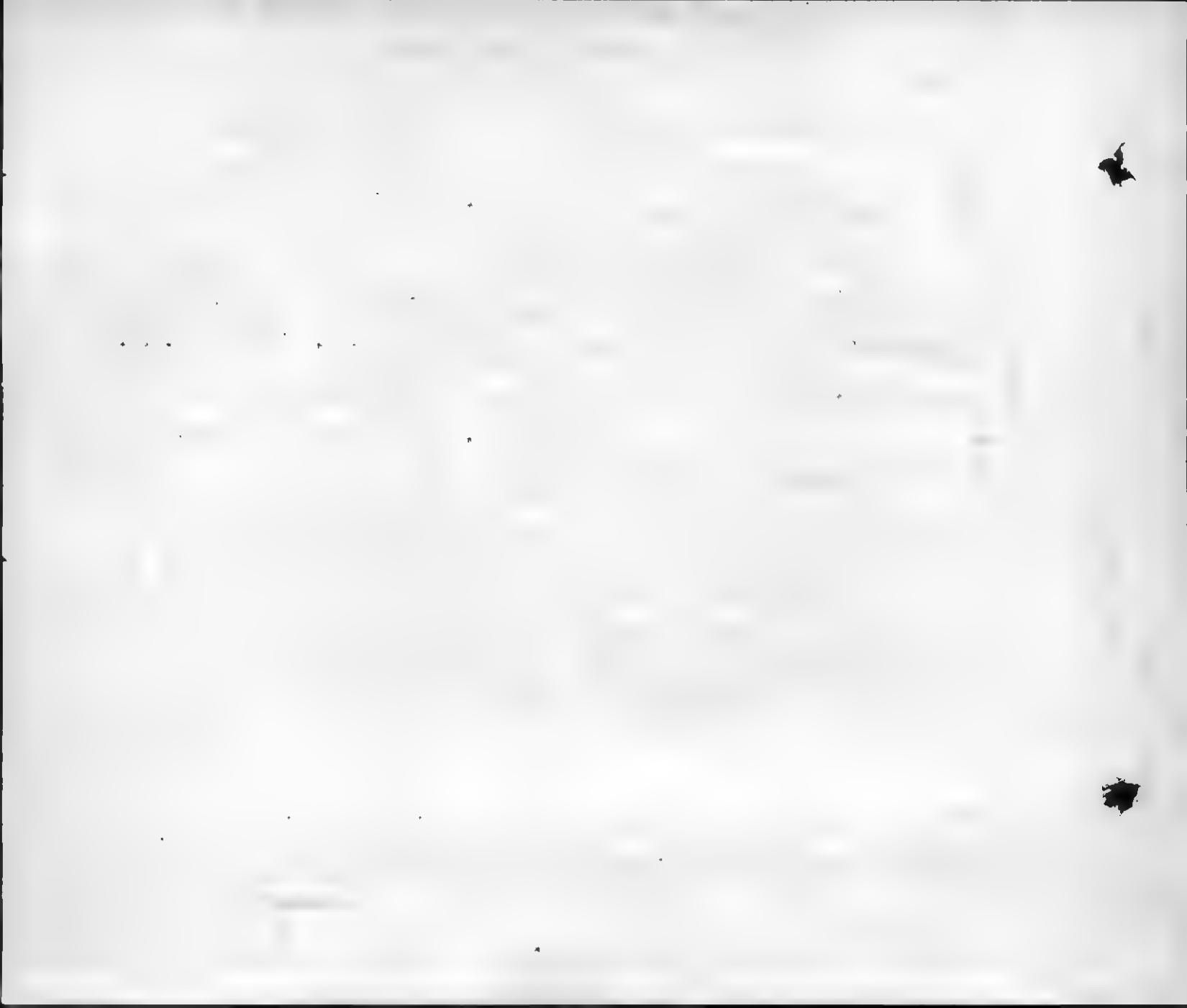
7338

CERTIFICATE OF DEATH

07360

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb 10 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		d. STREET ADDRESS 25½ W. Franklin Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First LILLIAN	Middle BEATRICE	Last WHITTINGTON	4. DATE OF DEATH June	Month June	Day 16	Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 6, 1902	9. AGE (In years last birthday) 55 yrs.	10. IF UNDER 1 YEAR Months 11	11. IF UNDER 24 HRS. Hours 11	12. IF UNDER 24 HRS. Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Seamstress		10b. KIND OF BUSINESS OR INDUSTRY Tent Fabricating		11. BIRTHPLACE (State or foreign country) Martinsburg, W. Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Tithian A. Blake			14. MOTHER'S MAIDEN NAME Florence Cookus				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Ex. no. or unknown) <input type="checkbox"/> (If yes, give war or date of service) no			16. SOCIAL SECURITY NO.		17. INFORMANT George F. Whittington Hagerstown, Maryland		
Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 416 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) <i>Rheumatic HEART Disease</i> 20415 INTERVAL BETWEEN ONSET AND DEATH 15 min							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/16, 1958, to 6/16, 1958, that I last saw the deceased alive on 6/15, 1958, and that death occurred at 7:45 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <i>Paul Harrison</i> M.D. 318 N. Potomac St. 6-17-58							
ACTUAL SIGNATURE							
PHYSICIAN'S NAME (Type) Paul Harrison, M. D. Hagerstown, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/19/1958		22c. NAME OF CEMETERY OR CREMATORIUM Broadfording Cemetery		22d. LOCATION (City, town, or county) Broadfording Maryland	
22e. FUNERAL DIRECTOR'S SIGNATURE Suter-Rouzer Funeral Home <i>R. Franklin Jr.</i>		ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE JUN 20 '58		24b. REGISTRAR'S SIGNATURE <i>Reed</i>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7339

CERTIFICATE OF DEATH

Reg. Dist. No. 302

07361

1. PLACE OF DEATH a. COUNTY <i>Maryland Washington</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Washington</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hagerstown</i>		c. LENGTH OF STAY IN 1b <i>6 days</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hagerstown</i>		d. STREET ADDRESS <i>112 S. Prospect St.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington County Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>MARY</i>		First <i>ELLEN</i>	Middle <i>WOOD</i>
4. DATE OF DEATH <i>03 June</i>	Month	Day <i>15</i>	Year <i>1958</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>August 4, 1888</i>
9. AGE (In years lost birthday) <i>69 yrs.</i>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <i>10</i> Days <i>11</i> Hours <i>0</i> Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Baby Sitter</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Hagerstown, Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>William Buchanan</i>	
14. MOTHER'S MAIDEN NAME <i>Ella Mc Kean</i>		15. SOCIAL SECURITY NO.	
16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mr. Richard E. Wood</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebralvascular accident (thrombosis)</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Cerebral Arteriosclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>42 days</i>	
DUE TO (c)		unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour a.m. <i>19</i> p.m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Jacksonville, Fla.</i>	
(County)		(State)	
21. I certify that I attended the deceased from <i>June 10, 1958</i> to <i>June 15, 1958</i> , that I last saw the deceased alive on <i>June 14, 1958</i> , and that death occurred at <i>1:00 A.M.</i> from the causes and on the date stated above. DST ADDRESS (Street, city or town, state) DATE SIGNED <i>6/16/58</i>			
ACTUAL SIGNATURE <i>William T. Layman</i>			
PHYSICIAN'S NAME (Type) <i>William T. Layman, M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6/17/1958</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Rose Hill Cemetery</i>		22d. LOCATION (City, town, or county) <i>Hagerstown,</i>	
(State)		Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Suter-Rouzer Funeral Home</i>		ADDRESS <i>Hagerstown, Md.</i>	
24a. REC'D BY REGISTRAR DATE <i>JUN 20 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Alv. Leach</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7340 CERTIFICATE OF DEATH

Reg. Dist. No. 07362

Items 13, 14 & 16, Film G-230 6/18/58 rec.

1. PLACE OF DEATH a. COUNTY Washington		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b life		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.		b. COUNTY Wash.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 234 Alexander St.,		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown		f. STREET ADDRESS 234 Alexander St.,		g. DATE OF DEATH 6 2 19 58		h. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Gerald		First Gerald		Middle Edward		Last Yonkers			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH March 27, 1918		9. AGE (In years last birthday) 40 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) meat cutter		10b. KIND OF BUSINESS OR INDUSTRY A & P Store		11. BIRTHPLACE (State or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. W.W. II 214-09-1655		17. INFORMANT Mrs. Lillian B. Yonkers		Address Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		DUE TO Coronary Occlusion		INTERVAL BETWEEN ONSET AND DEATH 1 hr					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		DUE TO Coronary Occlusion		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN					
DUE TO Arterio- Sclerosis									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 318 N. Potomac St.		(County) (State)	
21. I certify that I attended the deceased from 6-2 , 1958, to 6-2 , 1958, that I last saw the deceased alive on 6-2 , 1958, and that death occurred at 7-13 M, from the causes and on the date stated above. ACTUAL SIGNATURE Paul Harrison M.D.								ADDRESS (Street, city or town, state) Hagerstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 6-4-58		22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill		22d. LOCATION (City, town, or county) Hagerstown		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss		ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR JUN 4 '58		24b. REGISTRAR'S SIGNATURE Alfred			

